MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11653 CERTIFICATE OF DEATH 11670 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY Maryl and b. COUNTY Wicomico MARYLAND after c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b letely filled in by the Salisbury The law requires that the death certificate be executed within 24 hours Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Peninsula General Hospital 506 N. Robinson Street NO IX NAME OF First Middle 4. DATE Month Last Dov Year DECEASED Horace 196 (Type or print) DEATH by the attending physician and cardal ransit permit. Then please remave of YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER please remave lost birthday) Months Doys Hours March 31, 1903 white male WIDOWED DIVORCED and in any 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT Gas & Electric Co. COUNTRY? Machinist Tennessee 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remayal. Unknown Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service Lucy Amyx, wife, above (nee Melson) 219-03-6731 no crematian, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) be retained by the haspital or attending physician. DUF TO signed l burial Conditions, if ony, which gove rise to immediate couse (a). DUF TO stoting the underlying couse as the this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Health ! CERTIFICATION NO ATTENDING PHYSICIAN: lar 20g. ACCIDENT WAS UNDERLYING [20b, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) Hour a.m. foctory, street, office bldg., etc.) Not While ot work TO FUNERAL DIRECTOR: After age 3 shauld be filed with the Stot 21. I certify that (1) (this haspital) attended the deceased from_ 190 and that death occurred at 73671M, fram causes and on the date stated above. sow the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Dr. Wilbur A. Ellis, Medical Center, Salisbury, Maryland directar, shauld be

23c. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

23b. DATE THEREOF

8/7/67

3331 Brehms Lane

Schimunek Funeral Home

23d, LOCATION (City or Town)

Balto. Md.

1967

25o. REC'D BY REGISTRAR

(County)

2Sb. REGISTRAR'S SIGNATURE

Charles

(Stote)

VR A15 (4) 20 M 1/66 23a. BURIAL, CREMATION

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11671 CERTIFICATE OF DEATH death I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) physician and completely filled in by the funeral on please remave carban papers. Pages/1 and o. STATE b. COUNTY o. COUNTY Wicomico MARYLAND law requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ve carban papers. Pages event within 72 haurs aft write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d. STREET ADDRESS Peninsula General Hespital 0 NO Z YES Middle 3. NAME OF DATE Month Doy Year First Lost DECEASED 31 19 6 (Type or print) DEATH IF UNDER 1 YEAR | 1 IF UNDER 24 HRS. 9. AGE (In years S. SEX 6. COLOR OR RACE DATE OF BIRTH NEVER MARRIED lost birthdoy) Months Doys Hours WIDOWED DIVORCED 0910 2 Yrs. 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** ENGLEHARD 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME attending phys UNKNOU 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) UTWEN DO. st world lea INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO signed t Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse be retained by the hospital or attending this certificate has been use as the last. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO far 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work of work TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased from 1967, that (1) (we) last 19.6 7, and that death accurred at 9:40 PM, from causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 920 SIGNATURE ATTENDING STAFF PHYS. M.D. DIRECTOR 22d. ADDRESS PHYSICIAN'S 22c. NAME (Type) directar, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL CREMATION. REMOVAL (Specify) ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 wayles

Charles and the same

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Wicomico MARYLAND Maryland OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town)
Salisbury days Grasonville ban papers. within 72 ha e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS and completely filled Deer's Head State Hospital NO K 3. NAME OF First Middle 4. DATE Last Month Day Year DECEASED 1967 16 HERRERT RANDOLPH (Type ar print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 9. AGE (In years SEX 7. MARRIED DATE OF BIRTH NEVER MARRIED last birthday) m any WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician a during most of working life, even if retired) INDUSTRY ADORE 13. FATHER'S NAME crematian, ar remaval, 17. INFORMAN 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war ar dates of service) GRAJONU 18. CAUSE OF DEATH (Enter only one cause per lie the signed by the burial-transit burial, cremati PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o. Page 4 may be retained by the haspital ar attending physician. DUF TO Conditions, if any, which gave rise to immediate cause (a), DUF TO stating the underlying cause the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use Health YES X NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or town) (County) (State) factory, street, affice bldg., etc.) Hour o.m. Not While al wark 21. I certify that (I) (this flaspital) attended the deceased fram March 18 August 16 ta and that death occurred of 1228 A.M. from causes and on the date stated above. 1967 saw the deceased alive an August 22o. SIGNATURE 22b. DATE SIGNED /16/67 M.D. DIRECTOR director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL Deer's Head State Hospital, Salisbury, NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City ar Tawn) (State) (County) REMOVAL (Specify) REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 2 25b. VR A15 (4) 25M 1/67 DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11662 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY a. STATE b. COUNTY Wicomico Maryland Wicomico MARYLAND PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) b. CITY QR TQWN (If outside corporate limits, write RURAL and give nearest town) Day Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 508 S. Division St., Peninsula General Hospital YES NO FE 3. NAME OF Middle 4. DATE First Last Month Day Year 1967 DECEASED HYLAS BRITTINGHAM ALBERT DEATH (Type ar print) IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years 8. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** last birthday) Manths Days Hours Male White Aug.10,1899 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Retired Accountant Power & Light Co. COUNTRY ? Wicomico, Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME hen Farma Parsons John Brittingham the attending 1S. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war ar dotes of service) 17. INFORMANT 16. SOCIAL SECURITY NO 220-10-9657-A Mrs. Laura C. Brittingham See Sec 2 INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) buriol-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO inetastases where Canditians, if any, which gove rise to immediate cause (a), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) USe MEDICAL CERTIFICATION NO by the hospitol or for 20a. ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, affice bldg., etc.) Haur o.m. Nat While ATTENDING pe 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram_ . 1967 . ta O HOSPITAL OR ATTEND Page 4 may be retoined director, page 3 should should be filed with the 19 67, and that death accurred at M, fram causes and an the date stated above. saw the deceased alive an 22b. DAJÉ SIGNED 220. SIGNATURE-ATTENDING STAFF M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) WILLIAM P. SADLER M.D. MEDICAL CTR. SALISBURY, MARYLAND 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23a. BURIAL, CREMATION, 23b. DATE THEREOF Salisbury, Maryland REMOVAL (Specify) Parson Cemetery 8-4-1967 Salisbury, Maryland 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Hill Funeral Home VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11675 CERTIFICATE OF DEATH he law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH a. STATE b. COUNTY a. COUNTY Wicomico MARYLAND c. LENGTH OF STAY IN 16 carporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) RURAL and give r e. IS RESIDENCE d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Peninsula General Hospital NO NO YES NAME OF First Middle DATE Manth Day Уеаг DECEASED 19 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years lost birthdoy) SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Manths Haurs 25-19/0 and in any DIVORCED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY 2 during most of working life even if retired) 13. FATHER'S NAME 17. INFORMANT (Yes, na, ar unknown) (If yes give wor ar dotes of service) Broodwater None INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by attending physician. DUE TO Conditions, if ony, which gave rise to immediate couse (a) DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been prior to WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? use CERTIFICATION Health NO YES be retained by the haspital ar for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) 20c. TIME OF INJURY Month, Doy, Year Not While factory, street, office bldg., etc.) Haur a.m. at work pe that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram____ and that death accurred at 43.5 AM, fram causes and an the date stated above. saw the deceased alive an_ 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, shauld b 23d. LOCATION (City or Town) (State) 23c. NAME OF CEMETERY OR CREMATORY (County) 23a_BURIAL CREMATION 23b. DATE THEREOF REMOVAL (Specify) Downings Bunia 25b. REGISTRAR'S SIGNATURE 25o. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ocharles VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #1b 11664 DEATH CERTIFICATE OF I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY o. STATE ve carbon papers. Pages Treet, within 72 haurs after Com. Co MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs à Mardela d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) ₽. d. STREET ADDRESS IS RESIDENCE ON A FARM? filled R.D. #1 60 NO T YES NAME OF Middle 4. DATE Lost Month Doy Year campletely DECEASED (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR UNDER 24 HRS 7. MARRIED DATE OF BIRTH NEVER MARKIED remove lost birthdoy)
56 yrs. Months Hours in any Negro WIDOWED DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRYS and Wicomico 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, Brown 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) I(If yes give wor or dotes of service) MARdelA burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEE burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. 4200 DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse Dept. of Health priar to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO this certificate YES 10 20b. DESCRIBE HOW IN ORY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Yeor 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While ot work of work 21. I certify that (I) (this haspital) attended the deceased fram. that (I) (we) lost 2 7 19 67, and that death occurred at 4 A. M. fram causes and on the date stated above sow the deceased alive on. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL FUNERAL NAME (Type) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) EMOVAL (Specify) 250. REGISTRAR FUNERAL DIRECTOR DATE

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CEPTIFICATE OF DEATH

	1000	CERTIFICATI	E UF DEATH	110	67
	I. PLACE OF DEATH a. COUNTY Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceas a. STATE Maryland		sidence before admission)
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENCTH OF STAY IN 1b	c. CITY OR TOWN (If outside corpor	ate limits, write RURAL a	nd give nearest town)
)	d. NAME OF HOSPITAL OR INSTITUTION (if not in hi	ospital, give street address)	d. STREET ADDRESS 725 Spring Str	reet	e. IS RESIDENCE ON A FARM? YES NO
	R. NAME OF OECEASED (Type or print) Ettore	Middle	Last 4. DATE DF DEATH	Month Aug. 27	
	Male 6. COLOR OR RACE 7. MARRIED White WIDOWED	DIVORCED	Dec. 2, 1899	7 yrs.	Days Hours Min.
0	Restaurateur Re	IND OF BUSINESS OR NOUSTRY	11. BIRTHPLACE (County & State, or Milan, Italy		IZEN OF WHAT JNTRY? USA
	13. FATHER'S NAME unk		14. MOTHER'S MAIDEN NAME unk		
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unkown) (If yes give war or dates of service) unk		s. Mildred L. Capri	Address oglio, Salis	bury, Md.
	18. CAUSE DF DEATH (Enter only one cause per li	ine for (a), (b), and (c),]	11.0		INTERVAL BETWEEN ONSET, AND DEATH
	PART I. DEATH WAS CAUSED BY:	gestur fell	it failure		1612
1	Conditions, If any, which gave rise to immediate (b)	a pulmina	le		/mo
	cause (a), stating the underlying cause last.	linorary &	uplysema		grs.
3	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTED 20a. ACCIDENT WAS UNDERLYING 1 20b. E OR CONTRIBUTING 1 CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	TING TO DEATH BUT NOT RELA	TED'TO THE TËRMINAL DISEASE CONDIT	ION GIVEN IN PART 1(a)	19/ WAS AUTOPSY PERFORMED? YES NO
-		DESCRIBE HOW INJURY OCCU	RRED. (Enter nature of injury in Part	l or Part II of Item 18.)	
10000	20c. TIME OF INJURY Month, Day, Year 20d. If Hour a.m. While p.m. 19 at work	Not While factor	CE OF INJURY (Home, farm, ry, street, office bldg., etc.)	y or town) (Coun	ty) (State)
	21. I certify that (I) (this hospital) extends	2 / 7	8/7, 196/, to_	8/27, 196	Z, that (I) (we) last
	saw the deceased alive on 22a SIGNATURE	19.6/, and that	death occurred at M, from	the causes and on the	e date stated above. LE SICNED
	Cally Sudden	7 M.D.	ATTENDING MED. PHYS. DIRECTOR	STAFF PHYS. D 9/	2/67
1	22c. PHYSICIAN'S NAME (Type)		22d. ADDRÉSS	'/	
1	Burial, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Aug 29, 1967			TION (City, town or country), Maryland	1
	24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY RECISTR	17 1991 1m -10	A STATE OF THE STA
1	LeCompte Funeral Service,	osmorrage, war.	yland DASEP 7.198) I marca	10

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11679 11567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY delay is and 3 ta Page Mary land Baltimore Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (Il outside corporate limits, write RURAL and give nearest town) pup Baltimore e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS alone with farm 00 Route 50 & Hebron Road 7836 Hillsway Ave. YES NO X be executed within 24 hours after death. NAME OF First Middle 4. DATE Year Lost DECEASED NANCY CORRIGAN 8-25-67 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 8. DATE OF BIRTH 9. AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X lost birthdoy) Months Hours 9-9-10 White in any event within 72 haurs after death Female WIDOWED DIVORCED 4 shauld be farwarded to the Chief Medical Examiner's Office 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Maryland

14. MOTHER'S MAIDEN NAME Student IISA 13. FATHER'S NAME James J. Corrigan Thelma D. Hinz 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? .⊆ 16. SOCIAL SECURITY NO. 17. INFORMANT burial-transit permit. (Yes, no, or unknown) (If yes give wor or dotes of service) Mr. James J. Corrigan -- Same 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Asphyxia IMMEDIATE CAUSE (a) writing the word This certificate shauld Third degree burns minutes Conditions, if ony, which gove rise to immediate couse (o). DUE TO stoting the underlying couse and be used 19. WAS AUTOPSY PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) ar remaval, PERFORMED? NO please execute the certificate. 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 3 should PRIMARY XX or CONTRIBUTING Passenger in auto struck from behind by another vehicle. CAUSE OF DEATH crematian, 20f. (City or town) 20e. PLACE OF INJURY (Home, lorm, (County) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Tart. 50 & Hebron Rd. Hour 2020. Not While may be retained far yaur FUNERAL DIRECTOR: Page While of work of work 8-25-6719 Wicomico. Md. Page , 21. I certify that I took charge of the remains described above, held on Autopsy Inquiry X, and in my opinian Inspection X deoth resulted from Natural cours Accident X Suicide . Undetermined manner Homicide the funeral directar. CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER Health priar SIGNATURE O DEPUTY Earl L. Royer. DEPUTY MEDICAL EXAMINER August 26, 1967 Camden Ave. Salisbury, Md. Address (Street, city, town, or county) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 23o. BURIAL, CREMATION, REMOVAL (Specify) 0 New Cathedral Cem VR A15ME (5) Leonard Ruck, Inc., Baltimore, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH 11668 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 是三台於於 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death eath and campletely filled in by the funeral remove carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Wicomico MARYLAND Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 3vrs. 3mos. Salisbury Salishurv papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO 20) Center Street NAME OF Middle 4. DATE Year DECEASED (Type or print) Ida Frances Crockett DEATH IF UNDER 1 YEAR 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH lost birthdoy) Hours March 17, 1876 and in any WIDOWED DIVORCED Famal . White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Housewife INDUSTRY COUNTRY? Somerset County, Maryland USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remaval, William Dize Rebecca Stewart 17. INFORMANT
Mrs. Mabel C. Humphreys (Daughter)
204 Center Street, Salisbury, Maryland 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) ONSET AND DEATH signed by Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse be detached far use as the State Dept. af Health priar ta WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED YES NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH N/A (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. foctory, street, office bldg., etc.) Not While TO FUNERAL DIRECTOR: After May 27. 19 6/1, to August 20, 1967, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from_ saw the deceased alive an Angust 20, 19 67, and that death accurred at 5.30M, fram causes and on the date stated above. 220. SIGNATURE 2268 DATES ISNED? director, page 3 shauld be filed v DIRECTOR 22d ADDRESS Dee r NAME (Type) A. C. Mitchell, M.D. Head State Hospital, Salisbury 23o. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) BUT 1 a 1 August 23,1967 Parsons Cemetery Salisbury, Maryland REGISTRAR 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR COMPANY, SALISBURY, MARYLAND VR A15 (4) 25M 1/67 DATE AUG 2 2 1967

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 11681 pinous 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before edmission) e. COUNTY b. COUNTY 00 MARYLAND death. b. CITY OR TOWN (if outside corporata limits. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town) write RURAL and give nearest town) hours after filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES | NO papers. n 72 hor completely 3. NAME OF First Middle 4. DATE Last Month Day Year DECEASED OF (Type or print) DEATH - within 19 carbon 5. 6. COLOR OR RACE IF UNDER 24 HRS 7. MARRIED 9. AGE (In years | IF UNDER 1 YEAR NEVER MARRIED 99 and last birthdey) Months Deys Min. Hours WIDOWED DIVORCED certificate been signed by the attending physician please remoye USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY done during/most of working life, avea if retirad) any ous 0 13. FATHER'S NAME MOTHER'S MAIDEN NAME 14. death c and 'AY Then the 15. WAS DECEASED PVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address removal (Yes, ng, or unkown) (Ifyesgivewerordetesofservice The law requires that permit. the hospital or attending physician. 18. CAUSE OF DEATH [Enter only one cause par lina for INTERVAL BETWEEN D DEATH 9 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) cremation, the burial-transit DUE TO Conditions, if eny, which (b) gave rise to immediate cause DUE TO burial, (a), stating the underlying After this certificate has ceuse lest (c) PHYSICIAN: PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) CERTIFICATION 19. WAS AUTOPSY use as PERFORMED? YES NO T prior 20e. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Part I or Part II of item 18.) detached for OR CONTRIBUTING [] CAUSE OF DEATH of Health (IF EITHER, NOTIFY MEDICAL EXAMINER) ATTENDING be retained by MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm, Month, Dey, Yeer 20f. (City or town) (County) (Stete) factory, streat, offica bldg., atc.) While Hour a.m. Not While DIRECTOR: 3 should be del at work et work 19 Dept. p.m (this hospite attended the deceased from. , that (I) (we) last State M. M, from the causes and on the date stated above ... and that death occurred at may OR SIGNATUR DATE 22e ATTENDING MED. STAFF SIGNED O HOSPITAL death. Page 4 r BIRECTOR PHYS. PHYS. rector, page ; M.D. PHYSICIAN'S 22d. NAME (Type) LOCATION (City, town or county) BURIAL CREMATION. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. 23a. 23Ь. 23c. (State) REMOVAL (Specify) O.F.B OH 24 FUNERAL DIRECTOR'S SIGNATURE BY REGISTRAR ADDRESS 25e. 25b. REGISTRAR'S SIGNATURE VR A15 (4) DATE 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11583 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY a STATE b. COUNTY Wicomico signed by the attending physician and campletely filled in by the fur burial-transit permit. Then please remove carban papers. Pages 1 burial, cremation, ar removal, and in any event, within 72 hours after Maryland MARYLAND Wicomico b. CITY OR TOWN (If outside corparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn)
Salisbury days Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Deer's Head State Hospital NO F 222 Maryland Avenue 3 NAME OF 4. DATE Doy Year DECEASED JANE (Type ar print) DEATH IF UNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED last birthday) Haurs WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTAPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during mast af warking life, even if retired OVEN HUME 13. FATHER'S NAME MOTHER'S MAIDEN NAME 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na or unknown) (If yes give war ar dates af service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY Aspiration pneumonia IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Malignancy of right paratid gland vears Conditions, if ony, which gove rise ta immediate cause (a), DUE TO stating the underlying couse certificate has been State Dept. of Health priar to 19. WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO I 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED (City ar town) (Caunty) (State) Hour 'a.m. factory, street, office bldg., etc.) Not While TO FUNERAL DIRECTOR: After to August 28 21. I certify that (1) (this hospital) attended the deceased from... saw the deceased alive an August 28 19.67, and that death accurred at 7:48 M, fram causes and an the date stated above. 22b. DATE SIGNED STAFF 8/28/67 Mary Land 22d. ADDRESS C. Mitchell, M. D. Head State Hospital, Salisbury, 23g. BURIAL CREMATION. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATOR 23d. LOCATION (City or Town) (State) 6 2Sa. REC'D BY REGISTRAR VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11672 CERTIFICATE OF DEATH 11684 death. death. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY icomico Wicomico o. COUNTY MARYLAND after b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest tawn) c. CITY OR TOWN (If autside corparote limits, write RURAL and give nearest tawn) CLENGTH OF STAY IN 16 Willards within 72 hours The low requires that the death certificate be executed within 24 hours Salisbury 9 IS RESIDENCE ON A FARM? d. STREET ADDRESS ond completely filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD YES X NO Peninsula General Hospita 4. DATE Middle Manth Year 3. NAME OF First DECEASED Thomas James 196 DEATH (Type ar print) remove col and in any even IF UNDER 24 HRS DATE OF BIRTH 9. AGE (In Grears S SEX 6. COLOR OR-RACE 7. MARRIED NEVER MARRIED Jost birthdoy) Manths Haurs May 13, 1896 WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT 1Db, KIND OF BUSINESS OR 1Da. USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired) physicion Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME buriol, cremotion, or removol, ottending phys Rufus A. Dennis Sigaurney Lewis 16. SOCIAL SECURITY NO 17. INFORMANT Address 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, no, or unknown) (If yes give war or dates af service 217-36-0997 Dennis Willards. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) signed by the burial-tronsit p PART I DEATH WAS CAUSED BY Poge 4 may be retained by the hospital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse hos been be detoched for use os the Stote Dept. of Health prior to last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) MEDICAL CERTIFICATION NO O FUNERAL DIRECTOR: After this certificate OR ATTENDING PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, farm, (County) (State) 2Dd INIURY OCCURRED (City or town) 20c. TIME OF INJURY Manth, Day, Year factory, street, office bldg., etc.) Haur o.m. Not While at wark at work 21. I certify that (I) (this hospital) attended the deceased from 1967, and that death occurred at 100 M, from couses and on the date stated above. 3 should director, page 3 should should be filed with the 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. **ATTENDING** DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) (County) BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF Pleasant Willarda 25b. REGISTRAR'S 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4 20 M 1/66

THE RESERVE OF STREET contraction and the second CONTRACTOR STATE OF THE PROPERTY OF THE PARTY OF THE PART

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission) a. COUNTY b. COUNTY Wicomico Maryland MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 125 Onley Road 125 Onley Road NAME OF 4. DATE Middle Month DECEASED (Type or print) DERICKSON HARRY HOLLOWAY DEATH August 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | and last birthday) Months | Devs WIDOWED Male DIVORCED March 26.1902 10a. USUAL OCCUPATION (Give kind of work BIRTHPLACE (County & Stale, or foreign country) done during most of working life, even if retired) Roxanna, Delaware Retired Plumber Plumbing 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME James L. Derickson Luvenia B. Hickman 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Mrs. Clara Belle Derickson (Wife) (Yes, no, or unkown) | (If yes give war or dates of service) 125 Onley Road, Salisbury, Maryland No 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate cause DUE TO (a), steting the undarlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY CERTIFICATION as 20a. ACCIDENT WAS UNDERLYING T 20b. DESCRIBE HOW INJURY OCCURED, (Enter netuse of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED 1 20e. PLACE OF INJURY (Home, ferm, Month, Dey, Yeer 20f. (City or town) fectory, straet, office bldg., etc.) Hour a.m. Not While at work at work OR 21. I certify that (I) (this hospital) attended the deceased from......19.6., and that death occurred at M, from the causes and on the date stated above, saw the deceased alive on...... 220. SIGNATURE ATTENDING PHYS. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Camden Ave., Salisbury, Maryland Dr. William D. Gray 23d. LOCATION (City, town or county)
Salisbury, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, | 23b. DATE THEREOF REMOVAL (Specify) Parsons Cemetery 0.58 August 10,1967 Burial 24 FUNERAL DIRECTOR'S SIGNATURE

COMPANY, SALISBURY, MARYLAND

ND STATE DEPARTMENT OF HEALTH

VR A15 (4)

Wicomico

e. IS RESIDENCE ON A FARM?

YES NO

1967

IF UNDER 24 HRS.

Hours

INTERVAL BETWEEN ONSET AND DEATH

mo.

PERFORMED? NO L

(Steta)

22b. DATE

(Stete)

12. CITIZEN OF WHAT COUNTRY?

USA

(County)

August

his winder was his? . . . avv meters 458 Section of the sectio

director, VR A15 (4) 25M 1/67 NAME (Type)

23b. DATE THEREOF

8-10-67

23a. BURIAL, CREMATION,

Cremation

FUNERAL DIRECTOR

WAS AUTOPSY PERFORMED? NO (County) (State) 19 67, that (I) (we) last 6 19 67, and that death accurred at 22.1. M, from causes and an the date stated above. _ADDRESS_ A. C. Mitchell, M. D. Head State Hospital, Salisbur 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) Silverbrook Crematory Wilmington, N. Castle, Rel ADDRESS 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE and seem

e. IS RESIDENCE ON A FARM?

YES NO

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Year

Day

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Days

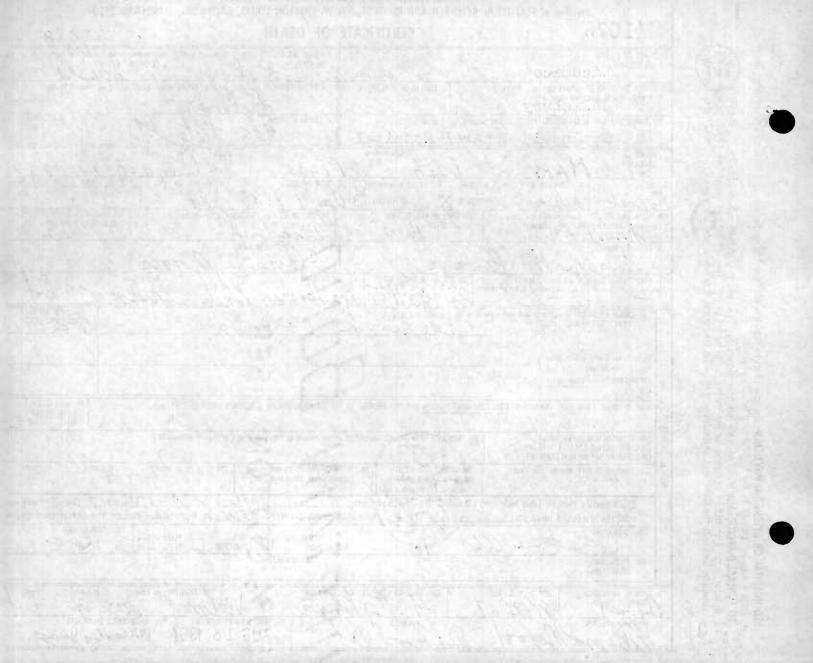
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11687 death. 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH a. COUNTY b. COUN Wicomico MARYLAND PHYSICIAN: The low requires that the death certificate be executed within 24 hours after ve corbon papers. Pages 1 event, within 72 hours after c LENGTH OF STAY IN 1b c, CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) the b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) filled in by e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital YES NO NO 3. NAME OF Middle DATE Month Day Year remove corbon ottending physicion and completely permit. Then please remove carbon DECEASED DEATH UG US (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. AGE (In years DATE OF BIRTH S. SEX COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths Dovs Hours WIDOWED DIVORCED G YIS. ond many 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) COUNTRY 2 during mast af warking life, even if retired) **NDUSTRY** e069 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremotion, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO JNFORMAN1 (Yes, ng. grunknown) (If yes give war ar dates af service INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a) (b), and (c). ONSET AND DEATH buriol-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a signed by Page 4 may be retained by the hospital or attending physician. DUE TO buriol Conditions, if ony, which gave rise to immediate cause (a) DUE TO stoting the underlying couse prior to l hos been as the lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAXED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION 3 should be detached for use with the State Dept. af Health YES W NO O FUNERAL DIRECTOR: After this certificate 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year Hour a.m Not While factory, street, affice bldg., etc.) While at work at wark 19-1, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram 1967, and that death occurred of 1238. M, from causes and an the dote stoted above. saw the deceased alive an 22b. DATE SIGNED 224 SIGNATURE ATTENDING director, poge 3 should be filed w DIRECTOR PHYS. M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) (County) 23b. DATE THEREOF BURIAL CREMATION. REMOVAL (Specify) SREEN ACATS 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 2Sb. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11688 death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY a. COUNTY a. STATE Wicomico MARYLAND 24 hours after b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest flawn) write RURAL and give negrest town) event, within 72 hours Salisbury the attending physician and completely filled in by sit permit. Then please remaye carbon popers. P carbon popers. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 80 Peninsula General Hospital YES I NO requires that the deoth certificate be executed within 3. NAME OF Manth 4. DATE Day Year DECEASED DEATH (Type ar print) AGE (In yours IF UNDER 24 ARS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH Manths birthday) Days Hours X WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of wark dane KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10b. BIRTHPLACE (Coupty & State for fareign country) during mask of working life, even is retired) COUNTRY? INDUSTRY 10WELVER 13. FATHER'S NAME MOTHER'S MAIDEN NAME or removol, 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknawn) (If yes give war ar dates af service) 16. SOCIAL SECURITY NO INFORMANT signed by the atter buriol-tronsit permi buriol, cremotion, o INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ottending physician. DUE TO Canditians, if any, which gave (b) rise to immediate cause (a), DUE TO stating the underlying cause os the this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO YES [Page 4 may be retained by the hospital or Por 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ō be detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) Not While TO FUNERAL DIRECTOR: After 70,19 7, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. 1960/ 3 should by with the S and that death accurred at 51157 M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE ATTENDING DIRECTOR M.D. ed 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL NAME (Type) director, g MANE OF COMPLERY OF CREMATORY 23b. DATE THEREOF LOCATION (City or Town) (County) 23a. BURIAL CREMATION. REMOVAL (Specify) herwon 25b. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15

MAKYLAND STATE DEPAKTMENT OF HEALTH



uneral in 24 hours after director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours a retained by the hospital or attending physician. The law requires that the death certificate be execute. ATTENDING PHYSICIAN:

TO HOSPITAL death. Page 4

A15 15M 7-62 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH TIGAG

_										m	
1.	PLACE OF DEATH				2	USUAL RESIDEN	ICE (Where de			nce before	admission)
	Wico	mico		MARYLA	IND	a. STATE Mary	1and	b. COUN	Wicomi	0	
		f outside corporete limits,	c.	LENGTH OF STAY		c. CITY OR TOWN		orate fimits, write			vnl
	write RURAL and Sali	sbury		Adm. in 1 7/8/67			sbury			. 2	2-1
1	d. NAME OF HOSPIT	AL OR INSTITUTION (if	not in hospital	, give street address	:)	d. STREET ADDRESS					ESIDENCE
		nsula Genera	al Hosp			118 /		mon Road			NO
3.	NAME OF DECEASED	First		Middle		Last	4. DATE OF	Month			•
	(Type or prinf)	SALL	Υ	MARTHA		FOOKS	DEATH	Aug	just 17	19	7
5.	SEX	6. COLOR OR RACE 7	. MARRIED	NEVER MARRIED	B. D	ATE OF BIRTH	9	. AGE (In years	IF UNDER 1 YEAR		
	Female	White	WIDOWED [·i1 24, 19	05	62 yrs.	Months Days	Hours	Mln.
10	a. USUAL OCCUPATI	ON (Give kind of work	10b. KIND	OF BUSINESS OR IN	NDUSTRY	11. BIRTHPLACE (Cou	inty & State, or	foreign country)	12. CITIZEN	OF WHAT	COUNTRY?
		rking lifa, evan if retired) SS	Shirt	t Company		Newark, Ma	aryland		USA		
13	. FATHER'S NAME				14	MOTHER'S MAIDEN					
	Edward K	ing Jones			1912	Olivia Wh	ittingt	on			
15	. WAS DECEASED EVE	R IN U.S. ARMED FORCE	ES? 16. SO	CIAL SECURITY NO.		ORMANT		Address			
(1	4.1	yasgive war ordatas of ser		10-8306	Mr	Donald R.	· Fooks	(Son)		. Man	1
-	NO I 18. CAUSE OF D	EATH Enter only one c			1 114	151 Lockwood	od Uriv	e, 511ve		J, Mar	
	PART I. DEATH	WAS CAUSED BY:	0	10201	Toot	TI Car	7(10-			NSET AND	
	1508	MMEDIATE CAUSE (a)		i e ees	-02	ac see	and	Gurco			
	13	DUE TO	0	054	- M	2500	10/100	-1		1	- N/
	Conditions, if any			Enam	3000	L Coo	produce	Jul 1		om	
	gave risa fo immediata cause (a), stating tha underlying DUE TO										
	cause last. (c)										
CERTIFICATION	PART II. OTHER	SIGNIFICANT CONDITION	ONS CONTRI	BUTING TO DEATH	BUT NOT R	ELATED TO THE TERMI	INAL DISEASE	CONDITION GIV	EN IN PART 1(a)	PERFC	DRMED?
10	20- ACCIDINE MA	C INDEDIVING D 1	DECCRIE	T HOW INDIVIDUO	CLIDED /F		Da a Las Da a H		1	YES	NO 1
CERTI		CAUSE OF DEATH MEDICAL EXAMINER)	ZOB. DESCRIE		A	nter natura of injury in	Part I or Part II	of item 18.)			
SAL	20c. TIME OF MIJUE	RY Month, Day, Year	20d. INJL	JRY OCCURRED 20		OF INJURY (Home, far		or town)	(County)		(State)
MEDICAL	Hour a.m.	19	While at work	Not While at work	factory,	street, office bldg., etc	c.)				
	21 L cortify th	at (II) (this hospita	l) attended	the deceased	from	2/12	1067 to	8-17	10(0)	that (1)	(wa) lad
	21. I certify that (I) (this hospital) attended the deceased from 1967 to 6.7 to 6.7 to 1962 that (I) (we) last saw the deceased alive on 1962 and that death occurred at 1. AM, from the causes and on the date stated above.										
	22a. SIGNATURE				10 In					221	. DATE
	Joh	m 500	ulls	eley_	M.D.		MED. DIRECTOR	STAFF PHYS.	August	17/1	SIGNED
	22c. PHYSICIAN'S NAME () YPO) Dr. John T. Bulkeley S. Salisbury Blvd. & Pine Bluff Rd.										
						Salisbury	, Maryl	and			10 to at abid
23	REMOVAL (Specify)	August 19		Hi COMICO				sbury, N		(S	itata)
	Burlal		, 170/	ADDRESS	Tello		-		SISTRAR'S SIGNA	ATLIDE	
24	HOLLOWAY	& COMPANY,	SALISB		LAND		AUG 18		Ochania	C	er.
	110					DATE	MI 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10.33.37	A		

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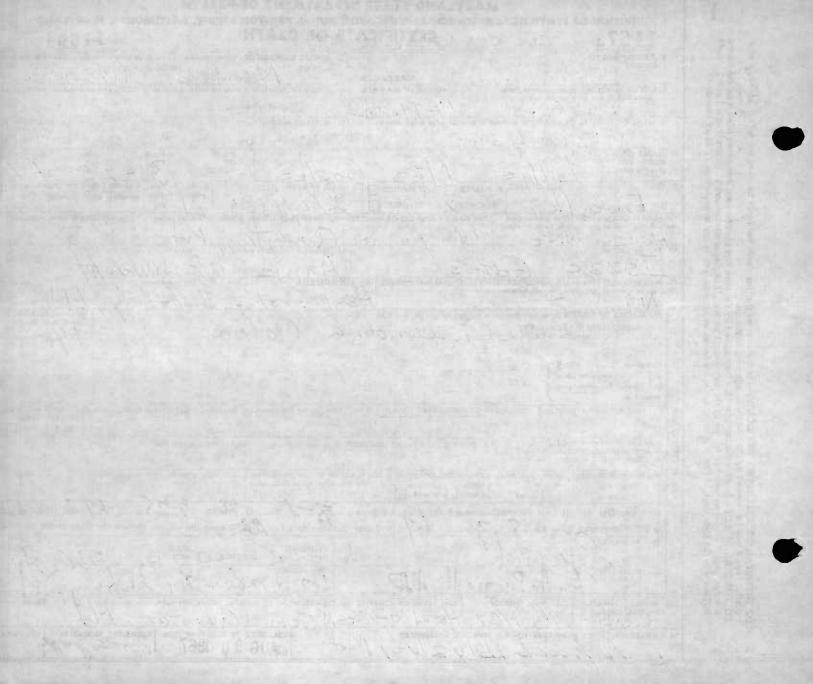
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11678 CERTIFICATE OF DEATH 11690 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COLINTY o STATE b. COUNTY Wicomico MARYLAND Marvland Wicomico b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give negrest town) 129 Days Salisbury Salisbury popers. .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS event, within 72 ON A FARM? R.D.#4, Snow Hill Road Deer's Head State Hospital Salisbury Md. YES NO 3. NAME OF carbon Middle 4. DATE Month Doy Year DECEASED (Type or print) Tda Goffigon Mae 67 DEATH 19 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In veors IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED remove lost birthdoy) Months Dovs Hours or removal, and in any WIDOWED X October 4,1888 Female White DIVORCED ond 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT attending physician of sermit. Then please during most of working life, even if retired)
Housewife USANTRY? **INDUSTRY** Worcester County, Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John W. Dickinson Esther Jane Johnson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Mrs. Margaret G. Smith (Daughter) R.D.#4, Snow Hill Road, Salisbury, Md. permit. (Yes, no, or unknown) (If yes give wor or dotes of service) buriol, cremotion, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: -tronsit ONSEL AND DEATH Cerebral Thrombosis signed by 1 IMMEDIATE CAUSE (o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital or ottending physicion. DUE TO buriol-Conditions, if ony, which gove Arteriosclerosis Generalized Years (b) rise to immediate couse (a). DUE TO stoting the underlying couse be detoched for use os the State Dept. af Heolth priar to lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPS) PERFORMED? NO X certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH N/A (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Dov. Year 20e, PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) TO FUNERAL DIRECTOR: After this Hour 'a.m. foctory, street, office bldg., etc.) Not While While of work 21. I certify that (1) (this hospital) attended the deceased fram. deceased fram 14/5, 1967, ta 8/12, 1967, that (I) (we) last 19_67 and that death occurred at 8:45 PM, from couses and on the date stated obove. 8/12 , 1967, that (I) (we) last sow the deceased alive on, 22o. SIGNATURE 22b. DATE SIGNED X 8/14/67 M.D. DIRECTOR PHYS. director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Deer's Head State Hospital, Salisbury, Md. 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Salisbury, Maryland August 15,1967 Parsons Cemetery 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR VR A15 (4) Ocharles HOLLOWAY & COMPANY, SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND TE OF DEATH Item #2c & funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) . COUNTY a. STATE b. COUNTY 20 MARYLAND and b. CITY OR TOWN (if outside corporeta limits c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give negrest town) filled in hours after Sal isbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress d. STREET ADDRESS . IS RESIDENCE ON A FARM? completely Wilson Lane YES 🗌 NO T d papers. 72 3. NAME OF Middle Last 4. DATE Month Dev Yeer DECEASED OF (Type or print) DEATH carbon 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 9. AGE (In yeers B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS certificate be physician and Last birthdey) Months Days Hours WIDOWED DIVORCED dye 9/9 10e. USUAL OCCUPATION Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY foreign country) done during most of working life, even if retired) 13. FATHER'S NAME please 2 MOTHER'S MAIDEN NAME attending and 0 Then levol, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unkown) | (Ifyesgivawarordetasofservice) The law requires that permit. the hospital or attending physician. 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c). signed by INTERVAL BETWEEN P ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) cremation. burial-transit DUE TO has been Conditions, if eny, which (b) geve rise to immadiate causa burial DUE TO (e), stating the underlying as the PHYSICIAN: cause lest. certificate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY 0 CERTIFICATION PERFORMED? use prior NO for 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Pert II of item 18.) After this of Health OR CONTRIBUTING TO CAUSE OF DEATH defached (IF EITHER, NOTIFY MEDICAL EXAMINER) ATTENDING be retained by 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm,) 20f. (City or town) Month, Day, Yeer (County) (Stata) fectory, street, office bldg., atc.) Whila Not While Hour a.m. DIRECTOR: Dept. et work et work p.m. pe 19 21. I certify that (I) (this hospital) attended the deceased from...... 196. /, that (I) (we) last plnods State from the causes and on the date stated above. saw the deceased ..., and that death occurred at. may DATE 22e. SIGNATURE 22b. ATTENDING MED SIGNED TO HOSPITAL FUNERAL page with th PHYS. DIRECTOR PHYS. M.D Page 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) ector, filed death. 23a. BURIAL, CREMATION, | 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State 23c1 0:53 REMOVAL (Specify) REC'D BY REGISTRAR REGISTRAR'S 24 FUNERAL DIRECTOR'S SIGNATURE 25b. 196 VR A15 (4) 20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH 11680 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11692 The low requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY DRCESTER MARYLAND c. CITY OR TOWN (Ift autside carparate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN 1h b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) ALISBU filled in I d. NAME OF HOSPITAL OR INSTITUTION (It not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM NO R YES Middle 4. DATE 3. NAME OF First Hastings Mary 196 DECEASED (Type or print) DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED pirthdoy) Months Dovs Hours Female DIVORCED cremotion, or removal, and in any WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY TO VJEWIFE 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 00 5 ENARD 15. WAS DECLASED EVER IN U.S. ARMED FORCES?
(Yes, no, punknown) (If yes give/wor or dates of service) INFORMANT 16. SOCIAL SECURITY NO. 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) buriol-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Page 4 moy be retained by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse with the State Dept. of Health prior to CONDITION GIVEN IN PART 1(0) PART II. OTHER SIGNIEICANT CONDITIONS CONTRIBUTING. DEATH BUT NOT REVA 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) factory, street, office bldg., etc.) Not While ot work 21. I certify that (I) (this haspital) attended the deceased fram. and that death occurred at 3.43 M, from causes and on the date stated above saw the deceased alive an 22o. SIGNATURE M.D. PHYS. PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY (Stote LOCATION (City or Town) 23o. BURIAL CREMATION, 23b. DATE THEREOF YERGREEN 30 250. REC'D BY REGISTRARY FUNERAL DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, If institution, Residence before account)

						- L	000				
1. PLACE OF DEATH			2. USUAL RESIDEN	CE (Where dec			nce bafore admission)				
	mico	MARYLAND	a. STATE Mary	land	b. COUNTY	Wicomi	ico				
	foutsida corporate limits,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (rate fimits, write R						
Sali	giva nearest town) SDUFY		Salis	sbury			->-/				
	AL OR INSTITUTION (if not in h	ospitel, give streat address)	d. STREET ADDRESS				. IS RESIDENCE				
316 E	. Vine Street		316 1	E. Vine	Street		ON A FARM? YES NO NO				
3. NAME OF DECEASED	First	Middta	Lest	4. DATE	Month	Day	Yeer				
(Type or print)	MINNIE	VOS BURG	HASTINGS	DEATH	August	26	19 67				
5. SEX	6. COLOR OR RACE 7. MARR	JED XX NEVER MARRIED 1 8	DATE OF BIRTH	9.	AGE (In years II	UNDER 1 YEAR	IF UNDER 24 HRS.				
Female	White WIDOW	D	ecember 4,189	92	last birthday)	Months Days	Hours Min.				
10a. USUAL OCCUPATI	ON (Giva kind of work 10b.	KIND OF BUSINESS OR INDUSTR				12. CITIZEN O	OF WHAT COUNTRY?				
Housewife	rking lifa, even if retirad)					1100					
13. FATHER'S NAME			Worcester (county,	Maryland	dUSA					
William T.	Scott										
	R IN U.S. ARMED FORCES? 16	COCIAL ESCURITY NO.	Mary Kelle	у							
(Yes, no, or unkown) (If	yasgive war or dates of service)	Mı	r. Frank M. I	Hasting	Address Husbar	nd)					
No		20-01-9542 3	16 E. Vine S	treet.	Salisbur	v. Maryl	land				
	No 220-01-9542 316 E. Vine Street, Salisbury, Maryland (c).] 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PARTI DEATH WAS CAUSED BY ONSET AND DEATH										
	MAS CAUSED BY:	Nges Fine hea	A Faleul				1 das				
134X	DUE TO		1		-						
Conditions, if any, which 7 (b) generalized and lunders											
	gave rise to immadieta causa										
(a), stating the uncause last.	darlying										
	SIGNIFICANT CONDITIONS CO	INTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMI	NAI DISEASE C	ONDITION GIVEN	I IN PART I(a) I	VAS ALITOPSY				
QE AND THE STATE OF THE STATE O	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?										
S ACCIDING WA	relies lest	purders	c pa	lays	5		YES NO				
OR CONTRIBUTING	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or fart II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A										
3 20c. TIME OF INJUI		. INJURY OCCURRED 20e. PLA			or town)	(County)	(Stata)				
20c. TIME OF INJUI	Whi	ile Not While tact	ory, streat, office bldg., etc	" i							
-		nded the deceased from.	Jin .	196/10	Aus	10/7	that (I) (was last				
	- 10 (/)		App;	17.97/, 10./	(1		that (I) (we) last				
22a. SIGNATURE	saw the deceased alive on										
128. SIGNATURE	617118	/		MED.	STAFF	115700	22b. DATE SIGNED				
22c. PHYSICIAN'S	1 / Dale	M.	D. PHYS. Z	DIRECTOR [PHYS.	August	1967				
NAME (Type)	Dr. Robert T.	Adkins		and, Mar	vland						
22- BINDIAL CREMATIO		23c, NAME OF CEMETERY			TION (City, town		(Sana)				
REMOVAL (Specify)	ON, 23b. DATE THEREOF			230. LOCA	TION (City, fown	or county)	(State)				
Burial		967 Wicomico Men		Salis	sbury, Ma	ryland	1				
24 FUNERAL DIRECTOR		ADDRESS	25a.AU	E 3 Mess	96725b. 464	THE PHANT OF THE	the state of the s				
HULLUWAY	G CUMPANY, SALI	ISBURY, MARYLAND	DATE		U	U					

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 11694 11682 **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after deoth physician and completely filled in by the funeral err please remove carbon papers. Pages I and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence befare admission) PLACE OF DEATH o. STATE Maryland b. COUNTY Wicomico a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Salisbury d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) ON A FARM? R.D.#1, Meadow Bridge Peninsula General Hospital YES I NO please ramove carbon I, and any event, with NAME OF First Middle DATE Day Year DECEASED PERRY WILLIAM 19 (Type or print) DEATH IF UNDER 24 HRS. IF UNDER 1 YEAR S. SEX DATE OF BIRTH AGE AGE (In years last birthday) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months BabyDIVORCED August 2, 1967 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10g. USUAL OCCUPATION (Give kind of work done COUNTRY? during mast af warking life, even if retired) **INDUSTRY** USA Salisbury, Maryland none 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Perry Havey Edna Frances Muir Mr. Perry Havey (Father) Address
R.D.#1, Meadow Bridge Road, Salisbury, Md. IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, ar unknawn) (If yes give war ar dates of service) no 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (a) signed by be retoined by the hospitol or ottending physicion. DUE TO Canditions, if any, which gove rise ta immediate cause (a), DUE TO stoting the underlying cause os the TO FUNERAL DIRECTOR: After this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION WAS AUTOPSY PERFORMED? ed for use of Heolth p CERTIFICATION NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, (City ar town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (County) (Stote) Haur a.m. factory, street, office bldg., etc.) Nat While at wark at work 21. I certify that (1) (this haspital) attended the deceased from cureliat , 19 67, to Occurt 5, 19 67, that (1) (we) last Quest 5 19 67, and that deoth occurred of 7 % M, from causes and an the date stated obove. sow the deceased alive an 22b. DATE SIGNED 22a. SIGNAJURE ATTENDING MED. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Medical Center, Salisbury, Maryland William C Morgan director, 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify) August 8,1967 Park Wicomico Memorial Salisbury, Maryland 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66 HOLLOWAY & COMPANY, DATE SALISBURY, MARYLAND

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	THE REAL PROPERTY.			

	1	MARYLAND STATE DEPARTMENT OF HEALTH	
		11683 I Lem #10 F VITAL RECORDS #301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH	
	1	CERTIFICATE OF DEATH	21695
1		PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: o. CQUNITY b. COUNTY b. COUNTY	Residence befare odmissian)
	L	(D) COMICO MARYLAND MARULAND WE	preester
		WILE KUKAL and give nearest tawn)	and give nearest tawn)
	-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS d. STREET ADDRESS	A IS DESIDENCE
	1	Forbes Nursing Home	e. IS RESIDENCE ON A FARM? YES NO SA
	3.	NAME OF First Middle Last 4. DATE Month	Day Year
		OF DEATH 8	9 1967
	S.	last hirthday) M	FUNDER 1 YEAR IF UNDER 24 HRS.
	100	M Colored WIDOWED DIVORCED 1-13-1917 30 yrs.	
	dui	. USUAL OCCUPATION (Give kind of work done ng mast af working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & Stote, ar fareign country) LABORCE SUSSEX Co. Dela.	12. CITIZEN OF WHAT COUNTRY?
	13	ABOYER SUSSEX. O. Dela. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	413,7
		Jaco Herry Holland Annie Belle Mari	Tiny
	1S	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address s, no, of unknown) (Iff yes give wor or dates of service)	
	Ľ	214-12-5595 H. DAVIS Quillin-Sp. Berl	in, Md,
		18. CAUSE OF DEATH (Enter anly ane cause per line for (a)-(b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) When the course of	INTERVAL BETWEEN ONSET AND DEATH
		IMMEDIATE CAUSE (a) Arcenosic brighty -	4/14/10
		Canditions, if any, which gave	IIITI
		rise to immediate cause (a), stating the underlying cause DUE TO	
		lost. (c)	
	NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	YES NO NO
		OR CONTRIBUTING CLAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	MEDICAL	2Dc. TIME OF INJURY Manth, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Hame, farm, 2Df. (City or town)	(Caunty) (State)
	ME	Haur a.m. p.m. 19 While Nat While of work factory, street, affice bldg., etc.)	
		21. I certify that (I) (this haspital) attended the deceased fram 1967, to 9	, 19/, that (I) (we) las
		saw the deceased alive an 7-24 1967, and that death accurred at M, from causes and	an the date stated above
		M.D. ATTENDING MED. STAFF DIRECTOR PHYS.	8/10/69
		22c. PHYSICIAN'S 22d. ADDRESS	0/10/01
1		NAME (Type) NEVINS W. TODD MEDICAL CENTER	SALISBURY
-	23	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town)	(County) M Stote)
	2	BURIAI 10-12-6/ IVEW DEINE! DESTIN	TRAR'S SIGNATURE
	6	D II III I DECENT DEL DIL	liarles Judge.

BUY JE STO H DAVE ON HINDER CERTIN HE

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11696 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY Wicomico b. COUNTY Sicomico Maryland MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) and campierer, papers. Pag remave carbon papers. Pag Balisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Dykes Road Peninsula General Hospital YES NO M The law requires that the death certificate be executed within NAME OF 4. DATE Last Month Day Year the attending physician and campletely sit permit. Then please remave carbon DECEASED DSON (Type ar print) UGUST 6 19 DEATH SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last birthdoy) Months Days Hours 1894 and in any June 20. WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of wark dane KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10b. during mast af working life, even if retired)
Housewife COUNTRY? INDUSTRY Home Maryland Own 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME removal, Avery Nock Lurena Brittingham WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar unknown) (If yes give wor or dates of service) Maomi Lowe Dykes Road Salisbury, Md XX cremation, CAUSE OF DEATH (Enter only one couse per line for (g), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by be retained by the hospital or attending physician. DUE TO burial Conditions, if ony, which gove (b) rise to immediate cause (a), DUE TO stoting the underlying cause has been size as the lith prior to k last. WAS AUTOPSY PERFORMEO? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) for use Health NO this certificate 20o. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH 3 should be detached with the State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (State) 20c. TIME OF INJURY Month, Day, Year (County) Hour o.m. factory, street, office bldg., etc.) Not While at wark TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased from 190 / that (1) (we) last and that death accurred at 1520M, fram causes and an the date stated above. saw the deceased alive an 19 22a. SIGNATURE 22b. DATE SIGNED M.D. PHYS DIRECTOR PHYS. be filed 22d. ADDRESS 22c. PHYSICIAN'S Page 4 may NAME (Type) director, shauld BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) (County) Evergreen Berlin Worcester. 2Sq. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FUNERAL PIRECTOR Selbyville, Del. VR A15 (4) 20 M 1/66

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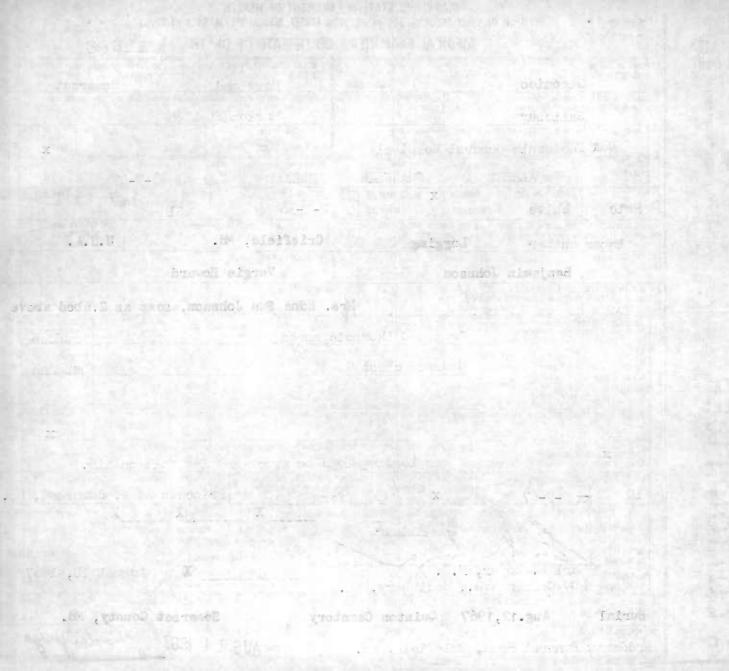
MARYLAND STATE DEPARTMENT OF HEALTH 1 6 6 5 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11697 CERTIFICATE OF DEATH ond 2 low requires that the death certificate be executed within 24 hours after death. filled in by the funeral papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Wicomico papers. Pages 1 MARYLAND Maryland Worcester b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Swrite RURAL and give neorest town) Pocomoke City d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Peninsula General Hospital NO 3 4th Street YES A MILES NAME OF First Middle DATE Month Day Year physicion ond completely, DECEASED In Tue (Type or print) DEATH 196 YEAR S SFX AGE (In years last birthday) IF UNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED remove Manths Days Haurs June 12, 1893 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind at work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY Maryland

14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Hughes Jennie Green John. 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, na, ar unknown) (If yes give war ar dates of service) 8316 Mrs. Sarah Hughes, Pocomoke City. Md Yes War cremotion, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) buriol-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause **O HOSPITAL OR ATTENDING PHYSICIAN:** The low re Page 4 may be retoined by the hospital or ottending os the prior to O FUNERAL DIRECTOR: After this certificate has been last 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use CERTIFICATION NO AT 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20g. ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) Stote Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (Caunty) (State) 20c. TIME OF INJURY Manth, Day, Year Haur a.m. factory, street, affice bldg., etc.) Nat While at work at work attended the deceased fram 190 , 1907, that (1) (we) last 21. I certify that (1) (this haspital) should and that death accurred at 12 32 M, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE DIRECTOR M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (State) BURIAL, CREMATION Burial (Specify) White Haven Md 8/5/67 Mt Wesley Cem 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. JUNERAL DIRECTOR VR A15 (4) New Church. V.a. 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11698 FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY 2, ond 3 to PM3. Page o. STATE b. COUNTY Wicomico MARYLAND Somerset Deportment of Maryl and b. CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town)
Salisbury c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) Marion Station d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? with form DOA Peninsula General Hospital Box 9 YES NO Item 18. Give Pages be executed within 24 haurs ofter death. NAME OF Middle First Last 4. DATE Year DECEASED ALBERT JOHNSON FRANKLIN 8-9-67 buriol-tronsit permit. File pages I and 2 with th (Type or print) DEATH 19 ecute the certificate, writing the word "pending" in pencil in Item 18. Give Page 4 should be forwarded to the Chief Medical Examiner's Office along S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In veors IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 31 yrs. Months Davs Hours 2-1-36 Male White DIVORCED and in any event within 72 hours after death WIDOWED 11. BIRTHPLACE (State ar foreign country) 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired)
timber cutter Logging UCOUNTRY ? Crisfield, Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Benjamin Johnson Vergie Howard .⊑ 16. SOCIAL SECURITY NO. 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown) (If yes give war ar dates af service Mrs. Edna Sue Johnson, same as 2.abcd above INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line far (a), (b), and (c).) onset and death sudden PART I. DEATH WAS CAUSED BY Ruptured thoracic aorta IMMEDIATE CAUSE (o) This certificate should DUE TO Crushed chest Conditions, if any, which gave sudden rise ta immediate cause (a), DUE TO 0 stating the underlying cause be used WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) removal, YES X NO 20a. EXTERNAL CAUSE WAS PRIMARY STORY CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3 should b 0 MEDICAL EXAMINER: Was loading logs on truck and log fell on him. CAUSE OF DEATH cremotion, MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or tawn) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.)

farm While Nat While 5 may be retained for your 10 FUNERAL DIRECTOR: Poge While at wark at wark Princess Anne, Somerset, Md. 10 KK 8-9-67 21. I certify that I taak charge of the remains described above, held an Autapsy X Inspection X. Inquiry X and in my apinian to buriol, the funerol director. death resulted fram Natural causes Accident X Suicide Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIG NATURE L. Royer, M.D. Earl DEPUTY MEDICAL EXAMINER August 10, 1967 EXAMINER'S Heolth 409 Camden Ave., Salisbury, Md. NAME (Type) Address (Street, city, tawn, ar caunty) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Tawn) (County) (State) BEMOVAL (Specify) Aug. 12, 1967 Quinton Cemetery Somerset County, Md. 256. REGISTRAR'S SIGNATURES ADDRESS 25g. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15ME (5) 1967 DATE AUG Bradshaw Funeral Home, Crisfield, Md.



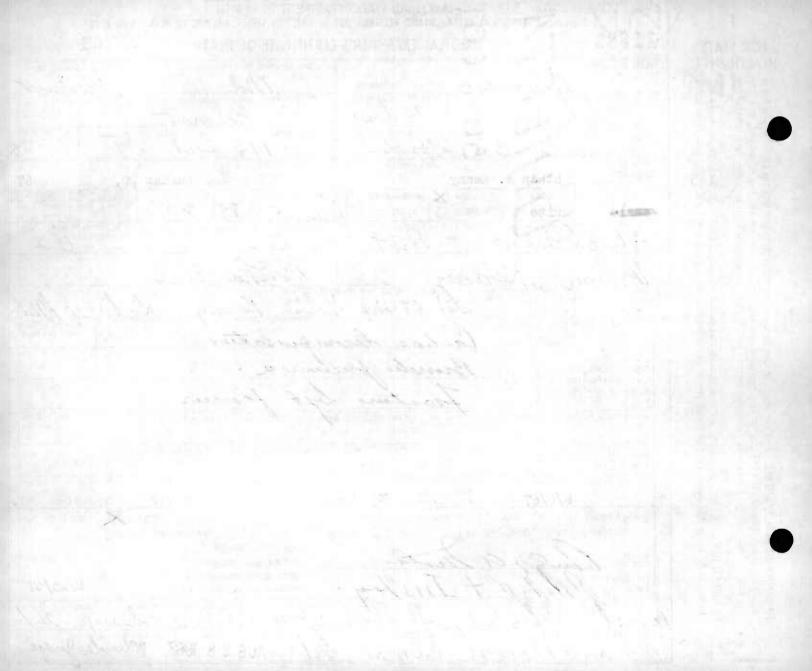
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11699 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours ofter death I. PLACE OF DEATH completely filled in by the funeral fove corbon popers. Pages 1 ond by every, within 72 hours after deal 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY b. COUNTY Wicomico Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) h02 days Easton d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Deer's Head State Hospital Rt. #3. Box 67 NO X 3. NAME OF First Middle 4 DATE Doy Yeor DECEASED flove corb ALDRIDGE JOHNSON 1967 (Type or print) DEATH 9. AGE (In years lost birthdoy) 5. SEX 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED X Hours M ond in ony WIDOWED DIVORCED and ren 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) physician c ease during most of working life, even if retired) INDUSTRY COUNTRY? MANGER 13. FATHER'S NAME cremation, or removal, attending phy SUSIE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes, give wor or dates of service 158-67-29 SUSIE CAUSE OF DEATH (Enter only one couse per Hige for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-tronsit burial, cremati PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) attending physicion. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse the hos been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Health 1 YES 7 NO TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 moy be retained by the hospital or TO FUNERAL DIRECTOR: After this certificate 200 ACCIDENT WAS LINDERLYING FT 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m. foctory, street, office bldg., etc.) ot wark at work 21. I certify that (I) (this haspital) attended the deceased fram July 18 1966 to August 1967, and that death occurred at 2:00PM, from causes and an the date stated above. saw the deceased glive an August 21 226. SIGNATURE 22b. DATE SIGNED ATTENDING 8/24/67 M.D. director, poge should be filed 22d ADDRESS 22c. PHYSICIAN'S C. H. Winnacott, M. D. Head State Hospital. Salisbury 23d. LOCATION (City or Town) 23o. BURIAL CREMATION 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) BEMOVAL (Specify) 2Sb. REGISTRAR'S SIGNATU BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11700 CERTIFICATE OF DEATH The low requires that the deoth certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH the ottending physician and completely filled in by the funeral sit permit. Then please ternove corbon papers. Pages I and o. STATE Maryland b. COUNTY o. COUNTY Wicomico b. CITY OR TOWN (If autside corparate limits, MARYLAND vent, within 72 hours after c. CITY OR TOWN (If autside corporate limits, write RURAL and give neorest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) **Fden** Salisbury e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d. STREET ADDRESS R.D.#2 YES NO [Peninsula General Hospita 3. NAME OF First Last 4. DATE Year DECEASED Jones THOUST 19 6 WASHINGTON (Type or print) DEATH IF UNDER 1 YEAR 8. DATE OF BIRTH 9. AGE (In years lost birthday) S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X Months Doys Hours MALE 82 yrs. WIDOWED DIVORCED September 27.1884 white 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired)
Retired Farmer INDUSTRY Wicomico County, Maryland Farming 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Virginia Hopkins William T. Jones Mr. Ralph William Jones (Nephew) R.D.#2, Eden, Maryland 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 218-20-5827-A No 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-transit Broncho on eumonia IMMEDIATE CAUSE (a) TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that Page 4 may be retained by the hospital or ottending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by DUF TO Conditions, if any, which gove rise to immediate couse (a). DUF TO os the stating the underlying couse 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for USe Health (y houmatord anthutis NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH N/A detached (IF EITHER, NOTIFY MEDICAL EXAMINER (City ar tawn) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) ot work 21. I certify that (1) (this haspital) attended the deceased from_ 1967, ta 8-15, 1967, that (1) (we) last 8-13 8-15 1967, and that death accurred at 500 M, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. DIRECTOR L M.D. 22d. ADDRESS 22c. PHYSICIAN'S Fruitland, Maryland Dr. Robert T. Adkins NAME (Type) director, should be 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23b DATE THEREOF 23a. BURIAL, CREMATION REMOVAL (Specify) August 17,1967Wicomico Memorial Park Salibbury, Maryland 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 HOLLOWAY & COMPANY, SALISBURY, MARYLAND 1967

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FOR STATE		11689 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1170	
AS Pose of the control of the contro	T.	PLACE OF DEATH O. COUNTY 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence of STATE b. COUNTY MARYLAND	e before admission)
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lond 2 with the State Depievent within 72 hours of		d. NAME OF HOSPITAL OR INSTITUTION (If pat trospital, give street address) d. STREET ADDRESS Renewalla Lon, Itaples 113 East II	e. IS RESIDENCE ON A FARM? YES NO
Abin 72	L	NAME OF DECEASED (Type or print) Ethan A. Kenny Middle Lost 4 DATE Month OF DEATH August 20,	Day Year 19 67
\$	1	White Widowed Divorced Uple 23 1860 Yrs.	Days Hours Min.
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	1S. (Ye	WAS DECEASED EVER IN 0.5. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes give war or dates of service) 201-07-200 Mollie Konny Address	nor And.
or removol,		18. CAUSE OF DEATH (Enter only one couse per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Audiae decompensation	INTERVAL BETWEEN ONSET AND DEATH
buriol, cremotion, or re		Conditions, if ony, which gave rise to immediate couse (a), DUE TO Branches preserve a -	
ој, сгеп		stating the underlying cause DUE TO (c) Fracture by femeur.	
	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISPASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED? YES NO
prior to	CERTIFICATION	20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell @ home	
its designoted ogent, prior	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8/6/67 19 20d. INJURY OCCURRED While at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Courted Wice	omico Md.
More		21. I certify that I taak charge of the remains described abave, held an Autapsy, Inspection, Inquiry, deoth resulted fram: Natural causes Accident, Suicide, Homicide, Undetermined manner	ond in my opinion
,		ACTUAL CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
Heolth or its designoted age		EXAMINER'S NAME (Type) ### The state of the	8/25/67
Heol	230 B	D. BURIAL CREMATION, 23b. DOTE THEREOF 23c. NAME OF CHARTERY OR CREMATORY 23d. LOCATION (City or Town) (1) REMOVAL (Specify) 823/67 At Slephons Susses	County) (Stote)
(5)(R)	24	ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIE DATE AUG 28 1967 OCLUME	NATURE PURCHE

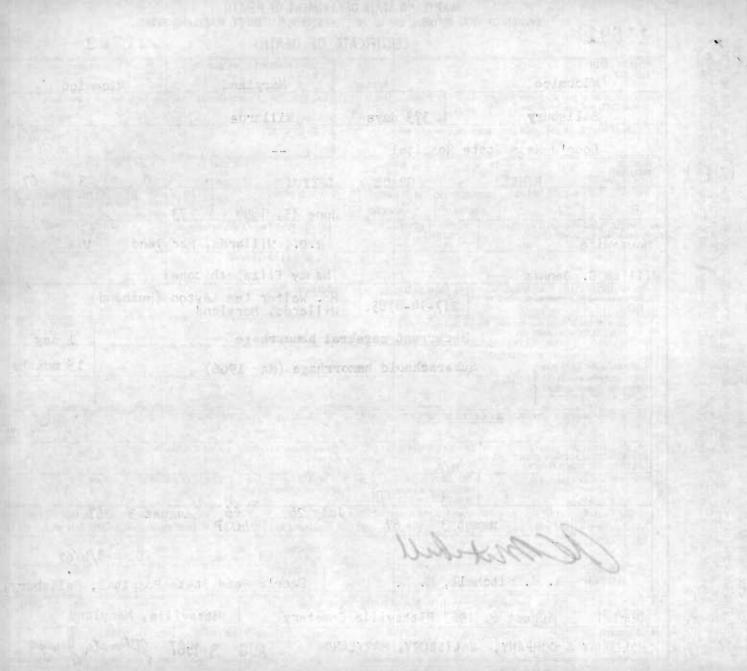


11 6 pivision of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11702 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) the attending physician and campletely filled in by the funeral sit permit. Then please remave carbon papers. Pages I fand o. STATE a. COUNTY b. COUNTY Wicomico MARYLAND Maryland Wicomico b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) papers. Pag kin 72 hours a Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Peninsula General Hospital Spring Hill Road YES NO [DATE NAME OF First Middle Lost Month Doy Year DECEASED LESH 196 (Type or print) **EDWARD** DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Male 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthdoy) Months Doys White WIDOWED DIVORCED August 12.1889 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) **INDUSTRY** COUNTRY? Retired Mfg. Representative-Road Bldg. Material-Frenchtown, N.J. 13. FATHER'S NAME LISA Lillian Delrimple John Lantz NFORMANT Mrs. Mary P. Morris Lantz (Wife) Spring Hill Road, Salisbury, Maryland 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dotes of service) 217-54-5738 crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line to) (o), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: mon an IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stoting the underlying couse as the TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT BELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO for 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) N/A detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (State) foctory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased fram 19 (96 ta 0 M, fram causes and an the date stated above saw the deceased alive an 19 5 and that death accurred at 22a, SIGNATURE 22b. DATE SIGNED August 1,1967 DIRECTOR M.D. director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Medical Center, Salisbury, Maryland Burton 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23b. DATE THEREOF 23a. BURIAL, CREMATION REMOVAL (Sperify) August 3,1967 Parsons Cemetery Salisbury, Maryland 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR COMPANY, SALIBBURY, MARYLAND **VR A15** 196 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

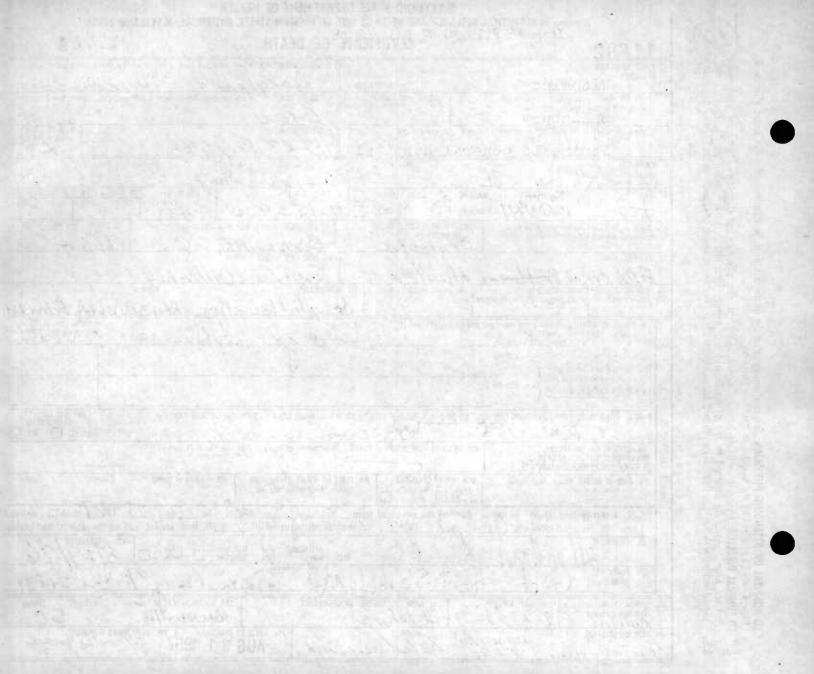
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11691 CERTIFICATE OF DEATH 11703 requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY G. STATE b. COUNTY Wicomico completely filled in by the fundamental pages prove carbon papers. Pages y event, within 72 hours after MARYIAND Maryland Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town)
Salisbury c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 373 days Willards d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Deer's Head State Hospital YES NO 3. NAME OF Middle 4. DATE last Month Year Dov DECEASED ETHEL 1967 (Type or print) GRACE LAYTON DEATH S SEX 6. COLOR OR RACE 7. MARRIED X 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED B. DATE OF BIRTH remove lost birthdoy) Months Hours cremation, or removal, and in any Tol WIDOWED DIVORCED June 15, 1894 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) attending physician overmit. Then please INDUSTRY COUNTRY? Housewife R.D., Willards, Maryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Nancy Elizabeth Jones William G. Dennis 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Mr. Walter Lee Layton (Address Husband) 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 217-14-8783B N₀ Willards, Maryland 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the buriol-transit p buriol, cremati PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Recurrent cerebral hemorrhage IMMEDIATE CAUSE (o) DUE TO 15 months Conditions, if ony, which gave Subarachnoid hemorrhage (May 1966) rise to immediate couse (a). DUF TO stoting the underlying couse hos been director, page 3 should be detoched for use as the should be filed with the State Dept. of Health prior to lost 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital or TO FUNERAL DIRECTOR: After this certificate YES [NO X 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A 20c. TIME OF INJURY Month, Dov. Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While factory, street, office bldg., etc.) While of work ot work 21. I certify that (I) (this haspital) attended the deceased fram July 26, 1966, to August 3, 1967, that (I) (we) last saw the deceased alive an August 3 19 67, and that death accurred at 100 P M, fram causes and an the date stated above. 220. SIGNATURE 22b. DATE SIGNED M.D DIRECTOR 2YH9 PHYS. 22c. PHYSICIAN'S 22d. ADDRESS A. C. Mitchell, M. D. NAME (Type) Deer's Head State Hospital, Salisbury BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LGCATION (City or Town) (Stote) Burial (Specify) Pittsville, Maryland August 6, 1967 Pittsville Cemetery 24. FUNERAL DIRECTOR ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Marles HOLLOWAY & COMPANY. SALISBURY, MARYLAND DATEAUG 1967



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6 Film #G392 9/18/67 ph or practice. CERTIFICATE 11704 OF DEATH death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) filled in by the funeral papers. Pages 1 and o. COUNTY o. STATE b. COUNTY Wicomico MARYLANO van papers. Pages I within 72 haurs after requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town)
Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Peninsula General NO [YES tarban NAME OF Middle Lost 4. DATE Ooy Year completely DECEASED 19 (Type or print) DEATH IF UNDER 1 YEAR DATE OF BIRTH AGE (In years lost birthdoy) IF UNOER 24 HRS and in any eve SEX NEVER MARRIED remove Doys Months Hours DIVORCED 4.3 yrs. puo 10o. USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal. INFORMANT IS WAS DECEASED EVER IN-U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. permit. (Yes, no, or unknown) (If yes give wor or dotes of service crematian, CAUSE OF DEATH (Enter only one couse per line far (a), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by attending physician. DUE TO burial, Conditions, if ony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse as the has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use Health CERTIFICATION NO. this certificate be retained by the haspital or 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH of o detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 3 shauld be detache with the State Dept. 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) Hour o.m. While Not While foctory, street, office bldg., etc.) ot work ot work 21. I certify that (I) (this haspital) attended the deceased fram and that death acturred at M, from causes and an the date stated above. TO FUNERAL DIRECTOR: saw the deceased alive an 220. SIGNATUR 22b. DAJE SIGNED STAFF PHYS. M.D. PHYS. **OIRECTOR** director, page should be filed **ADORESS** 22c. PHYSICIAN'S Page 4 may NAME (Type) NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (Stote) (County) REMOVAL (Specify) 3 DORN WILLS 25o. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11705 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. and completely filled in by the funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Somerset a. COUNTY o. STATEMaryland Wicomico MARYLAND b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) Princess Anne Salisbury bon papers. within 72 ha d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENC ON A FARM? NO X Peninsula General Hospital YES 3. NAME OF Middle DATE Day Year DECEASED DEATH (Type or print) B. DATE OF BIRTH 6. CQLOR OB RACE 7. MARRIED AGE (In years NEVER MARRIED last hirthdoy) Months Haurs Dovs Sept. 29, 1889 X WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR COUNTRY? during most of working life even if retired) INDUSTRY Somerset Co. . Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Daniel Miles Virginia Keene 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) Robt.C.Biggy Long, Westover, Md -IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-tronsit IMMEDIATE CAUSE (a) signed by physicion. DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate hos been Health prior to last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use NO YES Į0 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City ar tawn) (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (County) 20c. TIME OF INJURY Month, Day, Year factory, street, affice blda., etc.) Nat While at wark 21. I certify that (1) (this haspital) attended the deceased from. and that death accurred at M, fram causes and an the date stated above. saw the deceased alive an_ 22o. SIGNATURE DATE SIGNED DIRECTOR M.D. PHYS PHYS 22di ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County DERMOVA (pecify) 8/26/67 Manokin Presbyterian Princess Anne; Somerset ADDRESS 2Sb. REGISTRAR'S SIGNATURE 24. PLINERAL DIRECTOR Princess ocharles VR A15 (4) 20 M 1/66

Deserver." Walter Lobnati Patri C. Miller Petr Hope term are the effective or part (1.8 °C) in terminal district (4.8 °C) (4.8 °C). and the state of t Park Torrest

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11708 FOR STATE HEALTH DEPT. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admissian) a. COUNTY a. STATE b. COUNTY 2, and 3 ta PM3. Page Maryland Wicomico MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 with the State Departmen c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ecute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, " Page 4 shauld be farwarded ta the Chief Medical Examiner's Office alang with farm This certificate should be executed within 24 haurs after death. If cate, writing the ward "pending" in pencil in Item 18. Give Pages 1 Route 50 & Hebron Road 3602 Crossland Ave. YES NO F NAME OF Middle 4. DATE First Last Day Year DECEASED BRIAN LOUIS MARTIN 8-25-67 19 (Type or print) DEATH S. SEX IF UNDER I YEAR IF UNDER 24 HRS 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last histhday) Manths Haurs 3-3-45 Male White WIDOWED DIVORCED a burial-transit permit. File pages land 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT event within 72 haurs after de during mast af warking life, even if retired)

Teacher INDUSTRY COUNTRY? Maryland IISA School 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Ruth C. Conrad Herbert E. Martin 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, na, ar unknown) (If yes give war ar dates of service 217462032 Mr. Herbert E. Martin- Same 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Asphyxia IMMEDIATE CAUSE (a) execute the certificate, writing the ward any (Third degree burns Minutes Canditians, if any, which gave rise to immediate cause (a), . = DUE TO stating the underlying cause may be retained far yaur tiles. FUNERAL DIRECTOR: Page 3 shauld be used as last. crematian, ar remaval, 19. WAS AUTOPS) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? MEDICAL CERTIFICATION NO 20a. EXTERNAL CAUSE WAS PRIMARY A or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Driver of auto struck from behind by another vehiclo. MEDICAL EXAMINER: CAUSE OF DEATH 20e. PLACE OF INJURY (Hame, farm, 20f. (City ar tawn) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED (County) (State) Nat While factory, street, affice bldg., etc.) While be retained far yaur 8-25-6719 at wark at work Wicomico, Md. Route 50 & Hebron Rd 21. I certify that Latack charge of the remains described above, held an Autopsy and in my apinion Inspection X Inquiry [priar ta burial, the funeral director. death resulted from: (1) Natural causes (1) Accident (X) Homicide Suicide . Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Earl L. Royer, DEPUTY MEDICAL EXAMINER August 26, 1967 EXAMINER'S Hea!th NAME (Type) Address (Street, city, tawn, ar county) Camden Ave Salisbury, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23d. LOCATION (City or Town) (County) (State) 50 REMOVAL (Specify) Burial 24. FUNERAL DIRECTOR Moreland Memorial Cemb Baltimore VR A15ME (5) Leonard Ruck, Inc., Baltimore, Md.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11695 CERTIFICATE OF DEATH 11707 requires that the deoth certificate be executed within 24 hours after deoth 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY Wicomico o. STATE b. COUNTY Maryland Caroline MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) write RURAL and give nearest town) days Marvdel d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? within 72 tely miled Deer's Head State Hospital RD #1, Box 94 NO YES 3. NAME OF First Middle 4. DATE Month Doy Yeor DECEASED IOLA LOCKLEAR and in ony event, MAYULTANOS (Type or print) 1967 DEATH 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** 9. AGE (In years IF UNDER I YEAR DATE OF BIRTH IF UNDER 24 HRS. last birthdoy) Months Dovs Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most working life, even if retired) COUNTRY? 13. FATHER'S NAME or removol, MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT permit. (Yes, no, or unknown) (If yes give wor or dotes of service burial, cremation, CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
 PART I. DEATH WAS CAUSED 8Y: ONSET AND DEATH Uremia signed by IMMEDIATE CAUSE (o). attending physicion. 10000 DUE TO Conditions, if ony, which gove Chronic pyelonephritis (b) vears rise to immediate couse (a). DUE TO ficote hos been s for use os the k Heolth prior to b stoting the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? ATTENDING PHYSICIAN: The this certificote YES -NO TO 20o. ACCIDENT WAS LINDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. Not While foctory, street, office bldg., etc.) While ot work TO FUNERAL DIRECTOR: After of work 21. I certify that (1) (this hospital) attended the deceased from June 21 , 1967, to August 23, 1967, that (1) (we) lost be retoined sow the deceased plive or August 23 19 67, and that death occurred of 200 A M, from couses and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS Mary land NAME (Type) Maldve Deer's Head State Hospital. Salisbury 23o. 8URIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify FUNERAL DIRECTOR VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

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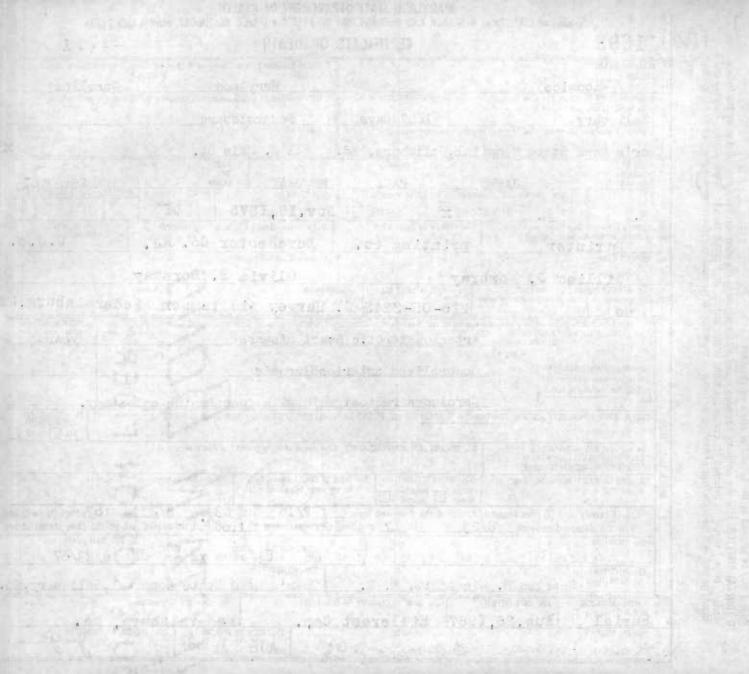
MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11711 CERTIFICATE OF DEATH completely filled in by the funeral name e darkon papers. Pages 1 and 2 requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY a. STATE b. COUNTY Wicomico MARYLAND Maryland Caroline b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 1647 Days Federalsburg Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 221 N. Main St. Deer's Head State Hospital Salisbury Md. YES 🗌 NO 3 3 NAME OF 4 DATE Day Year DECEASED (Type ar print) JAMES PAUL MOWBRAY DEATH 8 19 67 IF UNDER 24 HRS. 9. AGE (In years IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH NEVER MARRIED Manths Days Haurs Nov. 19, 1875 rema WIDOWED TO DIVORCED 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) IDa. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT during most of warking life, even if retired)

printer printing co. U.S.A. Dorchester Co. Md. 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME the attending physnsit permit. Then p Olivia P. Conaway William J. Mowbray 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar unknown) (If yes give war ar dates af service) J. Harvey Williamson Federalsburg, Md 5 216-05-3243 INTERVAL BETWEEN ONSET AND DEATH years 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: burial-transit Arteriosclerotic heart disease IMMEDIATE CAUSE (o) _ signed by DUF TO Conditions, if any, which gave Generalized arteriosclerosis rise ta immediate cause (a), DUF TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been as the (c) Carcinoma rectosigmoid with functioning colostomy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? NO TX be retained by the haspital or far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar tawn) (County) (State) 20c. TIME OF INJURY Manth, Day, Year Haur a.m. factory, street, affice bldg., etc.) Nat While of work ot wark 21. I certify that (I) (this haspital) attended the deceased fram___ 2/18 . 19 63 ato . 1967, that (1) (we) last shauld 19 67, and that death accurred all 1:68 M, fram causes and an the date stated above. saw the deceased alive an 8/23 22b. DATE SIGNED 220 SIGNATURE STAFF ATTENDING 8/23/67 M.D. DIRECTOR PHYS. directar, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott. M. D. Deer's Head State Hospital Salisbury Md. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (Caunty) (State) 23a. BURIAL, CREMATION, REMOVAL (Specify) Hillcrest Cem. Federalsburg Md Aug. 26. 1967 256 REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR It of provisionalist



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 700 CERTIFICATE OF DEATH 11712 requires that the deoth certificate be executed within 24 hours after deoth 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) physicion ond completely filled in by the funeral en pleose remove carbon papers. Pages I and o. COUNTY o. STATE b. COUNTY Wicomico MARYIAND Worchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Salisbury Pocomoke. City e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Peninsula General Hospital Pocomoke, Md. YES NO TO NAME OF 4. DATE First Last Year W DECEASED Melissa DEATH 46457 (Type or print) AGE (In years SEX 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH IF LINDER 2 7. MARRIED lost birthdoy) Months Hours Doys /67 and in any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? None None Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME signed by the attending phy buriol-tronsit permit. Then Sylvester Williams Annie Oliver 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) Annie Oliver Pocomoke. Md cremotion. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) inter curren ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO buriol. Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying cause os the or attending has been lost WAS AUTOPS' PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) YES NO couse TO FUNERAL DIRECTOR: After this certificate for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING Poge 4 moy be retoined by the hospital OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour o.m. foctory, street, office bldg., etc.) Not While of work 21. I certify that (1) this haspital) attended the deceased fram. 19641 ta should saw the deceased alive an 19 67, and that death accurred at 11 A.M. fram causes and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** MED. DIRECTOR director, poge 3 should be filed v 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. 23b. DATE THEREOF (Stote) REMOVAL (Specify) 6 67 Salisbury Green Cemetery Wicomico Arces 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** Charles VR A15 (4) 1967 DATE AUG 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11713 FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY ay is 3 to Page Wicomico of Maryland MARYLAND Wicomico pages 1 and 2 with the State Department CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Salisbury Parsonsburg d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) ON A FARM? d. STREET ADDRESS DOA Peninsula General Hospital YES NO P.O. Box 106 be executed within 24 haurs after death. I pending" in pencil in Item 18. Give Pages the Chief Medical Examiner's Office alang with fol NAME OF First Middle DATE Lost Month Doy Year DECEASED HOWARD PARKER W. 8-29-67 19 DEATH IF UNDER 24 HRS SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours 10-29-97 Male AA event within 72 hours after death WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Maryland

14. MOTHER'S MAIDEN NAME Farmer II.S.A 13. FATHER'S NAME "pending" in pencil permit. File John Parker Annie E. Mitchell 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 215-12-6553 Mazzie West Main St. Salisbury Md. No INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: burial-transit Coronary occlusion IMMEDIATE CAUSE (o) This certificate shauld please execute the certificate, writing the ward I directar. Page 4 shauld be farwarded ta the CP DUF TO and in any Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO stoting the underlying couse OS 19. WAS AUTOPSY PERFORMED? remayal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO EX pe 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 shauld Б PRIMARY Or CONTRIBUTING CAUSE OF DEATH. crematian, MEDICAL 20d. INJURY OCCURRED (City or town) 20c. TIME OF INJURY Month, Doy, Year 20e, PLACE OF INJURY (Home, form, (County) (State) foctory, street, office bldg., etc.) Yaur Hour o.m. Not While may be retained for your FUNERAL DIRECTOR: Page ot work ot work 21. I certify that I took charge of the remains described above, held on Autopsy Inquiry [X], Inspection X ond in my opinion deoth resulted from Natural couses AX. Accident | Suicide Undetermined monner Homicide be retained CHIEF MEDICAL EXAMINER priar to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY L. Royer, DEPUTY MEDICAL EXAMINER August 31, 1967 Earl EXAMINER'S S may ro FUNE Health Address (Street, city, town, or county) NAME (Type) Salisbury, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 23o. BURIAL CREMATION (Stote) Burial Burial 9/2/1967 Glass Hill Parsons burg Md 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A 15ME (5) DATSEP 1967 Home, Salisbury, Md.

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hours after TO HOSPITAL OB STENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may etained by the hospital or attending physician.

TO FUNERAL DIR. OR: After this certificate has been signed by the attending physician and completely fills by the funer director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TENDING PHYSICIAN:

VR A15 (4) 1SM 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1771/ 11714 11702

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where decen		dence bafore edmission)
Wicomico	MARYLAND	a. STATE Maryland	b. COUNTY Wicom	
b. CITY OR TOWN (if outside corporata limits, writa RURAL end give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corpore	te limits, write RURAL end giv	ve naerast town)
Salisbury		Fruitland		22.1
d. NAME OF HOSPITAL OR INSTITUTION (if not in	n hospital, giva streat eddrass)	d. STREET ADDRESS		. IS RESIDENCE
Peninsula General H	Hospita1	Carey Avenue	9	YES NO
3. NAME OF First DECEASED	Middle	Last 4. DATE OF	Month D	ay Year
. (Type or print) ELWOOD	FRANKLIN	PARSONS DEATH	August 2	26 19 67
5. SEX 6. COLOR OR RACE 7. MA	ARRIED X NEVER MARRIED 8		AGE (In years IF UNDER 1 YEA	
Male White WIDG	OWED DIVORCED N	ov. 19, 1906	60 yrs. Months Day	s Hours Min.
done during most of working life, even if retired) Service Station Attendar		Y 11. BIRTHPLACE (County & State, or for Wicomico County,		USA
13. FATHER'S NAME	SMELLING PARTY IN THE	14. MOTHER'S MAIDEN NAME		
Daniel Parsons		Minnie Lecates		
(Yes, no, or unkown) (Ifyesgive war or dates of service) 18. CAUSE OF DEATH [Enter only one cause PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which geve rise to immediate cause (a), stating the undarlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS	Perline for (a), (b), and (c). I Kup turned Abd Ar ferio sclero		d, Maryland	PERFORMED?
200. ACCIDENT WAS UNDERLYING 20b. OR CONTRIBUTING CAUSE OF DEATH UT IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURED	. (Enter natura of injury in Part I or Part II of	itam 18.)	YES XX NO
20c. TIME OF INJURY Month, Day, Year 2 Hour e.m.	20d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Homa, farm, 20f. (City or ory, street, offica bldg., alc.)	r lown) (County)	(Stata)
21. I certify that (I) (this hospital) a saw the deceased alive on	ttended the deceased from	9-25- 1967 to death occurred at 2:45, from the	ne causes and on the	That (I) (we) las date stated above.
228. SIGNATURE	In M	ATTENDING MED. DHYS. DIRECTOR	STAFF PHYS. Augus	226. DATE SIGNED 5t 28/1967
22c. PHYSICIANS NAME (Type) Dr. E. Kent	Carney	Medical Center, S	Salisbury, Mar	yland
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial August 29,1	23c. NAME OF CEMETERY 967 St. John's (ION (City, town or county) tland, Marylar	(State)
24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SA	ADDRECC	25a REC'D RY REGISTRA	AR 256. REGISTRAR'S SIGI	NATURE

Service Starter Withoutens - Dervice Mrs. Tolla Unite Throng (Wife OFFICE AND STREET STREET, MARRY LONG [4] [1] - [Warrand Some Till . To

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11703 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) . PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) and campletely filled in by the remove carbon papers. Pagin any event, within 72 haurs 12 days Salisbury Princess Anne d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Deer's Head State Hospital YES NO'N Route 3. NAME OF physician and campletely for en please remove carbon Middle Inst 4. DATE Doy Year DECEASED (Type or print) OF DEATH Roy Maylon S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS. Months Days Hours WIDOWED DIVORCED Male Colored 10o. USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life even if retired) COUNTRY? 13 FATHER'S NAME MOTHER'S MAIDEN NAME or remaval, attending phy permit. Then nderson WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ONSET AND DEATH **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital or attending physician. DUE TO Health priar taburial, Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? NO 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part 11 af item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) Hour o.m. Not While foctory, street, office bldg., etc.) ot work 21. I certify that (I) (this haspital) attended the deceased fram August 8. 1967, to August directar, page 3 should shauld be filed with the saw the deceased alive an August 20, 13,967, and that death accurred at 6.1.5 M, fram causes and an the date stated above. 220. SIGNATURE M.D. PHYSICIAN'S Head State Hospital, Salisbury, Md. Mitchell, NAME (Type) OF CEMETERY OR CREMATORY BURIAL CREMATION LOCATION (City or Town) (County) REMOVAL (Specify 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH

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		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
(A)		CERTIFICATE OF DEATH
funeral and a		1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY
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in 24 ho illed in papers. hin 72 h	80	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital d. STREET ADDRESS Peninsula General Hospital 417 Dighton AVe e. IS RESIDENCE ON A FARM? YES \sum NO
ed withi		3. NAME OF DECEASED (Type or print) MARTIN HOUSE 17 MARRIED 13 NEVER MARRIED 13 8. DATE OF BIRTH 19. AGE (In years IF UNDER 124 HRS
nd camp emove any eve		S. SEX 6. CÓLOR OR RAČE 7. MARRIED DIVORCED DIVORCED DIVORCED DIVORCED DIVORCED 106. USUAL OCCUPATION (Give kind of work done) 106. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT
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ne death cer attending p permit. The ion, ar rema		(Yes, na, ar unknawn) (If yes give war ar dates af service) Shirley Tindley 417 Dighton Ave.
equires that the death certifice physicon. signed by the attending physiburial-transit permit. Then pburial, cremation, ar remaval,		18. CAUSE OF DEATH (Enter only one cause per line factor), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO INTERVAL BETWEEN ONSET AND DEATH ONSET AND DEATH
		Canditians, if any, which gave rise to immediate couse (a), stating the underlying cause DUE TO
The law re attending has been se as the th prior ta		lost. (c)
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DING PHYSICIAN: The by the haspital ar at offer this certificate he be detached far use State Dept. af Health		20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State)
ATTENDING PHYSICIAN: stained by the haspital ar CTOR: After this certificate should be detached far uith the State Dept. af Heal ith the State Dept. af Heal		p.m. 17 atwark 🗀 arwark
ATTEN etained CTOR: / shauld vith the		saw the receased alive on 19, and that death accurred at 1226 M, from causes and an the date stated aba
ral or	1	22c. PHYSICIAN'S NAME (Type) ATTENDING PHYS. ATTENDING DIRECTOR PHYS.
Page 4 may be retained by the h C FUNERAL DIRECTOR: After this director, page 3 shauld be detag shauld be detag shauld be filed with the State Dep		23a. BURIAL (REMATION, REMOVAL ISpecify) 8-19-67 BAPT; 5+ 23c. NAME OF CEMETERY OR CREMATORY Subject to the su
2 2 2 0 0 VR A15 (4)	M	24. FUNERAD DIRECTOR ADDRESS DI LI 4 2 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS DI LI 4 2 DATE AUG 2 1 1967 ACHION SURGES ADDRESS DI LI 4 2 DATE AUG 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

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MARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 6. COUNTY o. STATE b. COUNTY 2, and 3 ta PM3. Page Department af Wicomico delay is Maryland MARYLAND b. CITY OR TOWN (If autside corparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give negrest town) Iyaskin d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d, STREET ADDRESS farwarded to the Chief Medical Examiner's Office along with form residence of Samuel Hull in Item 18. Give Pages be executed within 24 haurs after death. 3. NAME OF Middle First DATE Manth DECEASED CLIFTON REID COLUMBUS OF 8-5-67 (Type or print) DEATH IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years burial-transit permit. File pages 1 and 2 with 7. MARRIED NEVER MARRIED lost bigthday) Months 2-12-35 Male AA death. WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) INDUSTRY event within 72 haurs after - Exmex pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAM John Reid 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) (If yes give wor or dotes of service) .= 17. INFORMANT 16. SOCIAL SECURITY NO. Address pending" CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Shotgun wound of abdomen IMMEDIATE CAUSE (a) please execute the certificate, writing the ward This certificate shauld DUE TO in any Conditions, if ony, which gove (b) rise to immediate cause (a), DUE TO stoting the underlying couse 0 ond 0.5 used PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) remayal, CERTIFICATION be be 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3 shauld PRIMARY DO CONTRIBUTING 4 shauld d Shot at close range with shotgun by assailant. CAUSE OF DEATH crematian, MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) nome Hour a.m. While Not While be retained far yaur FUNERAL DIRECTOR: Page Tyaskin, Wicomico, Md. at work at work 21. I certify that I took charge of the remains described abave, held an Autapsy [A Inspection A burial, death resulted from the funeral directar. Accident Suicide Undetermined manner Natural causes Hamicide X CHIEF MEDICAL EXAMINER Health priar ta ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE

VR A15ME (5) 6M 1/67

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Earl

L. Royer, M.

August 8, 1967 NAME (Type) Camden Ave. Salisbury, Address (Street, city, tawn, or county) NAME OF CEMPTERY OR CREMATORY BURIAL CREMATION R MOVAL (Specify) 2Sq. REC'D BY REGISTRAR AUG Bivalve, Md.

DEPUTY MEDICAL EXAMINER

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Wicomico

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YES

12. CITIZEN OF WHAT

COUNTRY

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22. DATE SIGNED

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11720 FOR STATE HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY 2, and 3 to PM3. Page Maryland Wicomico Wicomico MARYLAND delay b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b write RURAL and give nearest town)
Salisbury Salisbury Depar #10 d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? farm 72 hours Pemberton Dr., R.D.#5 R.D.#5 YES NO Give Pages 24 haurs after death. Office alangements 3. NAME OF 4. DATE First Middle Manth Last Day Year DECEASED **RUFUS** RENFROW August 67 **JAMES** 19 (Type or print) DEATH IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED W 3 birthdoy) Months Days Hours Item 18. April 17,1914 White WIDOWED DIVORCED and 2 Male event 11. BIRTHPLACE (State or foreign country) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired) INDUSTRY COUSHIERY? Johnston, N. C. Aud d 'pending' in pencil in Chief Medical Examiner's 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME executed within _ Nodie Deans Leander Renfrow and Mr. Parrish S. Eure (Friend) WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, ar unknawn) (If yes give war ar dates af service) remayal 241-20-2338 Pemberton Dr., R.D.#5, Salisbury, Maryland CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Chronic alcoholism Б IMMEDIATE CAUSE (a) ward This certificate should crematian, DUE TO farwarded ta the Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? CERTIFICATION NO to YES please execute the certificate. 10 pe shauld be 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) agent, priar PRIMARY Or CONTRIBUTING CAUSE OF DEATH (City or tawn) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) factory, street, affice bldg., etc.) **DIRECTOR:** Page ot work ar its designated Inquiry X 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X and in my opinion for Natural couses X Accident Suicide Undetermined manner the funeral directar. death resulted fram Hamicide | retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE FUNERAL 1967 TO DEPUTY August Far 1 409 Royer, N.D. DEPUTY MEDICAL EXAMINER **EXAMINER'S** Camden Avenue, Salisbury, Md. Health (Address (Street, city, town, or county) NAME (Type) 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23g. BURIAL CREMATION. 23b DATE THEREOF (County) (State) 0 REMOVAL (Specify) R.D., Kenly, North Carolina August 5,1967 Renfrow Family Cemetery AUG 8 1967 24. FUNERAL DIRECTOR VR A15ME (5) HOLLOWAY & COMPANY, SALISBURY, MARYLAND

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1 6	I	tems 20b&21 Film 392 MARYLAND STATE DEPARTMENT OF HEALTH 9-6-67 ampivision of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	W	11703 CERTIFICATE OF DEATH
aurs after death by the funeral Pages 1 and 3.	er death	1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. STATE New Jersey New Jersey New Jersey
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in 24 ha filled in papers.	\$80	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) Peninsula General Hospital On A FARM? Peninsula General Hospital Peninsula General Hospital On A FARM? YES NO
de with	ent, wet	3. NAME OF DECEASED (Type or print) H. Right Middle Lost OF DEATH August 27 19 47 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
e execut and comprehensive	burial, crematian, ar remaval, and in any event,	MP/E WIDOWED DIVORCED 06-15-23 last birthday) Months Doys Hours Min.
icate be sician c	ıl, and ir	during most of working life, even if retired) Const. Eng. Chemical New Hope, Pa. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
th certifuling phy.	remava	James C. Robinson Elsie T. Robinson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
the deather the attence of attence of the attence o	tian, ar	(Yes, no, or unknown) (If yes give war or dates of service) 221-12-5243 Frances B. Robinson Same 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH
equires that the death certificate be ex physician signed by the attending physician and burial-transit permit. Then please rem	II, cremo	921.7 IMMEDIATE CAUSE (6) TOOLE TO
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VG PHYSIC the haspi or this certi	the Dept	20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, foctory, street, office bldg., etc.) at work at work at work
OR ATTENDING be retained by the INRECTOR: After a shauld be de	n the Sto	21. I certify that (I) (this hospital) attended the deceosed fram 15 / full 19 to 19 to 19 thot (I) (we) la saw the deceased olive on 24 full 7, and that deoth occurred at 5 AM, from causes and an the date stated above
OR AI be reto DIRECT	lled with	220. SIGNATURE M.D. ATTENDING MED. DIRECTOR DIPLOTOR 22b. DATE SIGNED 22b. DATE SIGNED 22c. PHYS. CIAN'S 22d. ADDRESS
TO HOSPITAL OR ATTENDING Page 4 may be retained by th O FUNERAL DIRECTOR: After the	uld be f	NAME (Type) Robert Adkins Salisbury, Md. 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State)
TO HO Poge direc	Sha U	Burial 8-29-67 At Sea, 10 miles out off Ocean City, Maryland
VR A15 (20 M 1/	(4)	Thomas F. Wallace Salisbury, Md. ADDRESS 250. REC'D BY REGISTRAR'S SIGNATURE CONTROL SIGNATURE CONTR

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11722 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. ond completely filled in by the funeral remove corban papers. Pages 1 gnd. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY Wicomico MARYLAND b. CITY OR TOWN (If autside carporate limits, c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. write RURAL and give nearest town)
Salisbury CORGETOWN d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? please remove corban papers. CEDA Peninsula General Hospital YES NO X event, with Middle DATE 3. NAME DF Dov Year DECEASED DEATH (Type or print) 5. SEX AGE (In veors 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH lost birthday) Months Doys Haurs and in ony WIDOWED DIVORCED 11. BIRTHPLACE (Caunty & State, ar foreign cauntry) 12. CITIZEN OF WHAT 1Do. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) INDUSTRY DELAWARE 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 16. SOCIAL SECURITY NO. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT Geong (Yes, no, ar unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), ond (c).) signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUF TO Interesceleration Heart Disease Conditions, if any, which gave rise to immediate cause (a). DUE TO as the prior tal stating the underlying cause Poge 4 moy be retained by the hospital or attending this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO far 20a. ACCIDENT WAS UNDERLYING □ 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2De. PLACE OF INJURY (Hame, farm, 20d. INJURY OCCURRED (City or town) (County) (State) 2Dc. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) O FUNERAL DIRECTOR: After 19 6 7, ta 8 19, 19 17, that (I) (we) last 21. I certify that (1) (this hospital) attended the deceased fram_ 18 - 19 67, and that death accurred at 750 M, fram causes and an the date stated above saw the deceased alive an_ 22b. DATE SIGNED 22o. SIGNATURE ATTENDING MED. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Medical FFORD director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23o. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Georgetown 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11723 24 hours after death deet filled in by the funeral papers. Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Wicomico MARYLAND within 72 hours after b. CITY OR TOWN (If autside corparate limits, c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Salis Dury d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) IS RESIDENCE d. STREET ADDRESS ON A FARM? Peninsula General Hospital YES NO [requires that the death certificate be executed within NAME OF DATE Doy 4. Year completely DECEASED OF 19 (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH MARRIED please remove and in any ev irthdoy) Months Days Hours WIDOWED DIVORCED and 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR during mat of working COUNTRY? attending physician permit. Then please 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar remaval, 40 wm INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give wor or dates of service burial, crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) attending physician. DUF TO Canditions, if any, which gave rise ta immediate couse (o). DUF TO stoting the underlying couse priar ta l been as the WAS AUTOPSY PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) ed far use of Health CERTIFICATION NO Page 4 may be retained by the haspital ar TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Yeor Haur o.m. factory, street, office bldg., etc.) While Not While at work at wark 21. I certify that (I) (this hospital) attended the deceased from ___, that (I) (we) last shauld M. fram causes and on the date stated above. and that death occurred at saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE **ATTENDING** M.D. PHYS DIRECTOR PHYS. director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 230 NAME OF CEMETIRY OR CREMATORS (Stote) 23a. BURIAL, CREMATION (County) RIMOVAL (Species 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Wicomico o. STATE Maryland o. COUNTY Wicomico MARYIAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give neorest town)
Salisbury 1.028 days Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Deer's Head State Hospital Baysinger Trailer Park YES NO 3. NAME OF First Middle 4. DATE Year DECEASED 1967 JAMES SMAIL 21 (Type or print) RUSSELL DEATH S. SEX 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Hours March 12, 1891 DIVORCED WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)
Groceryman Grocery CONNERX ? Accomac County, Virginia Store 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Arentha Marshall James S. Small 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Mrs. Blanche L. Small (Wife) (Yes, no, or unknown) (If yes give wor or dotes of service) 213-01-7218 Baysinger Trailer Court, Salisbury, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH N/A (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o m. foctory, street, office bldg., etc.) of work 21. I certify that (1) (this haspital) attended the deceased fram October 27, 1954, to August 1967, and that death accurred at 215 P.M. fram causes and an the date stated above. saw the deceased alive an August 21 22b. DATE SIGNED 22o. SIGNATURI 8/21/67 MD DIRECTOR Maryland 22c. PHYSICIAN 22d. ADDRESS NAME (Type) H. Winnacott. Deer's Head State Hospital, Salisbury 23o. BURIAL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) August 23,1967 Wicomico Memorial Park Salisbury, Maryland Buria 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE DATE AUG 25

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	Division of STATISTICAL RESEARCH AND RECORDS, 30	W. PRESTON STREET, BALTIMU	KE, MARYLAND 21201
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oujou	100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR NDUSTRY	11. SARTHPLACE (County & Stote, or foreign	country) 12. CITIZEN OF WHAT COUNTRY?
I verification	13. FATHER'S NAME Linith, J.	14. MOTHER'S MAIDEN NAME Mae John	ma:
ar ren	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 2/2-12-3700 13	NFORMANT Charles Hall	Bishpolle, Md.
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	21. I certify that (I) (this hospital) arended the deceased from sow the deceased glive on 1967, and that	t death occurred at APP M, fr	om causes and on the dote stoted obov
w with	and Silver M		STAFF PHYS. 22b. DATE SIGNED
airector, page 3 should be deforted for use as the should be filed with the State Dept. af Health prior to	22c.\ PHYSICIAN'S NAME (Type)	22d. ADDRÉSS V	
Silunia O	230. BURIAL (REMATION, REMOVAL (Specify) 8/24/67 Showed	R Cam. 5	ON (City or Town) (County) (Stote) howell wor. M.
Mo	24. FUNERAL DIRECTOR ADDRESS	Dele DATE ALIG 2.3	25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

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	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 48 Civic Avenue 3. NAME OF First Middle				give street address)		d. STREET ADDRESS	\ Y ¢/			e. IS RESID ON A FA YES	RM?
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hat .	Male Male	Whi	312	7. MARRIED WIDOWED				L 8 83	9. AGE (In yeors lost by yes.	Manths Day	Hours	Min.
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z	PART II. OTH	R SIGNIFICAN	. 1 -			2	THE TERMINAL DISEASE CO		VEN IN PART 1(a)		9. WAS AUTO PERFORME	ED?
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2	20a. ACCIDEN	WAS UNDERLY	YING 🗆			CURRED.	(Enter nature of injury in	Port I or P	ort II of item 18.)			
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11728 CERTIFICATE OF DEATH death. death and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Wicomico MARYLAND Maryland Wicomico requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) Salisbury isbur completely filled in the e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1141 S. Division St. Peninsula General Hospital YES NO F nt Pwithin 4. DATE NAME OF Middle Year First Lost Doy DECEASED 25 DEATH 19 6/ (Type or print) JOB Hu IF UNDER 1 YEAR IF UNDER 24 HRS. AGE In years S. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED eV remave lost birthdoy) Months Dovs Hours WIDOWED DIVORCED and in any male 11v 16, 1918 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY Bottling Company Providence, R. I. USA Employee 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removal, Ernestine Kellerman Elijah B. Steere (Wife) IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. permit. (Yes, no, or unknown) (If yes give wor or dotes of service) Dorothy W. Steere S. Division St., 218-05-8050 Salisbury. Yes Maryland War crematian. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE Les DUE TO burial, Conditions, if ony, which gove rise to immediate couse (a). DUF TO stoting the underlying couse Page 4 may be retained by the hospital ar attending priar ta O FUNERAL DIRECTOR: After this certificate has been as the lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? far use CERTIFICATION State Dept. of Health NO P 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached N/A (IF EITHER, NOTIFY MEDICAL EXAMINER (Stote) 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) 2Dc. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work ot work shauld be , to all 21. I certify that (I) (this haspital) attended the deceased fram. 196 19/2 7, and that death accurred at 5 fm M, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** August 25/1967 PHYS. M.D. DIRECTOR PHYS r, page 3 be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) David J. Gilmore Medical Center, Salisbury, Maryland directar, should be 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23b. DATE THEREOF 23o. BURIAL, CREMATION, REMOVAL (Specify) Walston, Maryland Bethel Cemetery August 29,1967 250. REC'D BY REGISTRAR 67 25by RESISTRAR'S SIGNATURE **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 DAAUG HOLLOWAY & COMPANY, SALISBURY, MARYLAND

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	CERTIFICATE	OF DEATH	11	729
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d. NAME OF HOSPITAL OR INSTITUTION (If not in h Peninsula Gen	nospitol, give street oddress) neral Hospital	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) Norwood		TAYLOR 4. DATE OF DEATH	August	29 1967
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	IDOWED DIVORCED J		45 birthdoy) Months [YEAR IF UNDER 24 HRS. Doys Hours Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Laborer	IOB. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or fore Maryland	eign country) 12. CITIZ COUL	IRY?
13. FATHER'S NAME Norman Taylor		14. MOTHER'S MAIDEN NAME Blanche Norw	rood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of serv	ice) 16. SOCIAL SECURITY NO. 17. IN	FORMANT .Clyde Taylor,	Address	
18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	r line for (g), (b), and (c).) My reardeal	Infareti		ONSET AND DEATH
Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying couse last. DUE TO (b) DUE TO (c)	Generalized athe	isclerons se	evere	?.
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200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (I	Enter noture of injury in Port 1 or Port	II of item 1B.)	
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19		E OF INJURY (Home, form, 20f. ry, street, office bldg., etc.)	(City or town) (Coun	ty) (Stote)
21. I certify that (I) (this haspital saw the deceased alive on	attended the deceased fram (death accurred at 32% M,		, that (1) (we) last date stated above
220. SIGNATURE	SAL M.D.	ATTENDING MED. PHYS. DIRECTOR [STAFF 22b. DAT	E SIGNED
22c. PHYŚICIAŃS' NAME (Type)		22d. ADDRESS		
230. BURIAL, CREMATION, 23b. DATE THEREOF 8/31/67	23c. NAME OF CEMETERY OR C Lorraine Pa	REMATORY 23d. LOC Bal	ATION (City or Town) (C	Maryland
(24. FUNERAL DIRECTOR)	ADDRESS An	ne, Ma DATAUG 3 1		

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY Pages 1 a. STATE Delaware b. COUNTY after Wicomico MARYLAND Sussex b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b y filled in by papers. Pagi thin 72 hours hours Salisbury Laurel d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Wicomico Nursing Home 4th St YES NO: within letely NAME OF W First Middle Last DATE 4. Month Day Year DECEASED remove carb (Type or print) TOTTE LENA DEATH 19 Aug. executed 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 ARS. last birthday) | Months | Days | Hours | Min. 7. MARRIED NEVER MARRIED WIDOWED TY DIVORCED physician n please r 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? and Housewife home Delaware OWn IISA certificate 13. FATHER'S NAME removal, MOTHER'S MAIDEN NAME the attending pl Edward Fowler Katherine Harris 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 0 (Yes, no, or unkown) (If yes give war or dates of service) death no cremation, Louise Totten. Laurel 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) INTERVAL DETWEEN ONSET AND DEATH been signed by t the burial-transit or to burial, crema PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the as th underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY 19. for use Health use certificate CERTIFICATI PERFORMED? YES NO. PHYSICIAN: I be detached for State Dept. of I 20a. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part | or Part || of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) this MEDICAL TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) factory, street, office bldg., etc.) Hour a.m. After While Not While p.m. at work at work P should ith the Leftify that (I) (this hospital) tended the deceased from DIRECTOR: age 3 should filed with the deceased alive or and that death occurred at M, from the causes and on the date stated above. 22b. DATE SIGNED MED. DIRECTOR M.D. PHYS. FUNERAL HOSPITAL pa Œ PHYSICIAN'S director, p 22d. ADDRESS NAME (Type) Beardsley Maryland Salisbury, Ave. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) Dremation 10 Silverbrook Cremeatory Wilmington REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR | 25b. Laurel, Del. VR A15 (4) 20M 1/65

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FO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filled with the State Dept. of Health prior to burial, creating the state Dept.	222	NAME (Type)	M.Beards	sley			22d. AOORE 207	Mary	land	Ave.,	Salisi	bury, Md
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11732

1. PLACE OF DEAT	'H		2. USUAL RESIDENCE (Where deceosed lived, i	if institution: Resid	ence before odmission)			
o. COUNTY	Wicomico		o. STATE Mary	land	b. COUNTY	een Anne's			
		MARYLAND			~ -				
	N (If outside corporate limits,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If or		write RURAL and g	ive neorest town)			
WING KOKAL	and give nearest town) Salisbury	307 days	Chur	ch Hill		17,2			
d. NAME OF HOS	SPITAL OR INSTITUTION (If not in hose	pital, give street address)	d. STREET ADDRESS			e. IS RESIDENCE			
	Doomin Hood Stor	to Woomital				ON A FARM?			
	Deer's Head Sta	*				YES NO			
3. NAME OF DECEASED	First	Middle	Last	4. DATE OF	Month	Day Year			
(Type or print)	THOMAS	GORDON	MALLS	DEATH	8	28 1967			
S. SEX	6. COLOR OR RACE 7. MAR	RIED NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In		R 1 YEAR IF UNDER 24 H			
M	WIDO WIDO		Sept. 7-19	a / lost birt		Doys Hours M			
	14			11 50	Yrs.	CITIZEN OF WHAT			
	ION (Give kind of work done ing life, even if retired)	Ob. KIND OF BUSINESS OR INDUSTRY	II. BIK IHPLACE (County	& Stote, or foreign count	11 0	CITIZEN OF WHAT			
TRUC			Q.A. Lo	. MARYL	AND	COUNTRY? USA			
13. FATHER'S NAM	E		14. MOTHER'S MAIDEN	NAME ,					
TH	OMAS	MALIS	SARF	IN HF	ATTS				
	EVER IN U.S. ARMED FOR CES?	16. SOCIAL SECURITY NO. 17.	INFORMANT	.,,	Address	11			
(Yes, no, or unknow	(If yes give wor of dates of service)			111/2 -	7	411			
Yes	WWIL	579-09-0391N	IRS. HELEN	IVALLS	- CHUR	CHILLI			
18! CAUSE OF	F DEATH (Enter only one cause per lin	ne for (o), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. I	PART I. DEATH WAS CAUSED BY:								
230	2 2) IMMEDIATE CAUSE (0)								
Carallel and Mark	Conditions, if ony, which gove) (b) Cerebral thrombosis with right hemiplegia								
(conditions, if ony, which gove is to immediate couse (a), (b) (b) (cerebral theomeosis with right nemiplegia									
	nderlying couse DUE TO								
lost.) (c)		2.00						
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CATION						PERFORMED?			
<u> </u>						YES NO			
20o. ACCIDENT	WAS UNDERLYING ☐ 20 ING ☐ CAUSE OF DEATH	b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in	Port 1 or Port !! of iten	n 18.)				
	TFY MEDICAL EXAMINER)								
7		Od. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form	n, 20f. (City or	town) (F	County) (Stote			
Hour	o.m.	While Not While for	ctory, street, office bldg., etc.						
		twork U otwork U	0.5			47			
21. I ce	rtify that (I) (this haspital) a	ttended the deceased fram	ctober 25	1900 , ta Aug	ust 20 19	7 <u>01</u> , that (I) (we)			
saw the	saw the deceased alive an August 28 19 67, and that death accurred at 1:30 AM, fram causes and an the date stated above								
22p. SIGNATU	IRE .	->+		HED CT		DATE SIGNED			
() (Lesionas C	Y P) (M	.D. PHYS.	MED. STA		3/28/67			
22c. PHYSICIA	IN'S	439	22d. ADDRESS	JAMESTON - TH		faryland			
NAME (T		tt. M. D.	Deer's He	ad State F	lospital.	Salisbury			
230. BURIAL, CREM		23c. NAME OF CEMETERY OR	CREMATORY	23d. LOCATION (C	ity or Town)	/(County) (Stote)			
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24. FUNERAL DIRE		ADDRESS //.	A A 2So. REC'	D BY REGISTRAR	2Sb. REGISTRAR'S	SIGNATURE			
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11733 CERTIFICATE OF DEATH within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH and completely filled in by the funer remove corbon popers. Pages 1 of o. COUNTY o. STATE b. COUNTY Wicomico MARYLAND buriol, cremation, or removal, and in any event, within 72 hours after c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Isbur e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) Peninsula General Hospital NO X YES Month 3. NAME OF First Middle DATE Doy Yeor DECEASED WES 196 DEATH (Type or print) requires that the deoth certificate be executed IF UNDER 1 YEAR IF UNDER 24 HRS. AGE (In years SEX 6. COLOR, OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) Months Doys Hours DIVORCED WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? physician a during most of working life, even if retired) HOME HOUSE WIFE 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME attending phys Address HESTER TO WAR **INFORMANT** WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO permit. (Yes, no, or unknown) (If yes give wor or dotes of service) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) the ONSET AND DEATH PART I. DEATH WAS CAUSED BY buriol-tronsit IMMEDIATE CAUSE (o' signed by DUE TO NEphropathy Conditions, if ony, which gove rise to immediate couse (o) DUF TO stoting the underlying couse Page 4 moy be retained by the hospital or ottending 3 should be detached for use as the with the State Dept. of Health prior to TO FUNERAL DIRECTOR: After this certificate has been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CERTIFICATION omposis terio sclerosis NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m foctory, street, office bldg., etc.) Not While 19 OR ATTENDING ot work ot work 21. I certify that (1) (this hospital) attended the deceased fram July 1967 to ond that death occurred at 143 M, from causes and an the date stated above. saw the deceosed alive an 22b. DATE SIGNED 220. SIGNATURE ATTENDING MED DIRECTOR M.D. PHYS. PHYS director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) THOMAS 23c. NAME OF CEMETERY OR CREMATORY (Stote) 23b DATE THEREOF LOCATION (City or Town) (County) 23o. BURIAL, CREMATION. REMOVAL (Specify) 2Sb. ADDRESS 24. FUNERAL DIRECTOR VR A15

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11735 CERTIFICATE OF DEATH PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH b. COUNTYSomerset a. COUNTY o. STAT Maryland Wicomico the ottending physician and completely filled in by the fur sit permit. Then please 1 event, within 72 hours after MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 Rural. Princess Anne d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS Peninsula General Hospital Middle First Year White OF August DECEASED 28 67 E. Clarence 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Doys Hours Feb. 26, 1890 white ond in any male DIVORCED WIDOWED 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 1Db. KIND OF BUSINESS OR INDUSTRY during most aftworking life, even if retired)
Tool & Die Maker Harrisburg. Pa 14. MOTHER'S MAIDEN NAME
Margaret Anne Himmelaugh 13. FATHER'S NAME John White 17. INFORMANT Md. Address IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war ar dates of service) Mrs. Ruth White; RFD#1, Princess Anne cremotion, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line far (9), (b), and (c).) signed by the buriol-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY METALIALIS ARCINOTA IMMEDIATE CAUSE (a) TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Poge 4 moy be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Conditions, if ony, which gave rise to immediate couse (a), DUE TO stating the underlying couse os the 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detached f te Dept. of l (IF EITHER, NOTIFY MEDICAL EXAMINER) 2De. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) 2Dd. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Yeor factory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased fram. 19 6 / ta 19 (2), that (1) (we) last M. fram causes and an the date stated above -2 19 67, and that death accurred at saw the deceased alive on 22b. DATE SIGNED 220 SIGNATURE **ATTENDING** 8-28-67 M.D. DIRECTOR PHYS. director, page 3 should be filed 22d. ADDRESS PHYSICIAN'S Mer NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY Beechwood Anne; Somerset 23a. BURIAL, CREMATION, 23b. DATE THEREOF 8/30/67 23d. LOCATION (City or Town)
Princess An BRENOVAL Specify) **ADDRESS** REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Princess Annem

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CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, If institution, Residence before edmission) show a. COUNTY b. COUNTY Wicomico Maryland Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL end give nearest town) Salisbury Salisbury 2. Pages Pe d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street eddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? Peninsula General Hospital Leonard Mill Box 273 YES NO completely papers. NAME OF DATE Middle Month Day DECEASED OF CHARLOTTE WHITMYRE DEATH 19 67 (Type or print) August and cor 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 3 last birthday) Months | Days Hours WIDOWED X DIVORCED [December 16,1904 62 Female White physician 10a. USUAL OCCUPATION (Give kind of work гетоме 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired Housekeepina Baltimore, Maryland LISA 13. FATHER'S NAME attending George Lehr Margaret Kreuder 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) | (If yes give wer or detes of service) Miss Marquerite Lehr (Sister) Cartref, Bryn Mawr, Pa. 19010 No 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c). INTERVAL BÉTWEEN has been signed by ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if env. which (b) geve rise to Immediate cause DUE TO (e), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+)| 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH ached MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ' 20f. (City or town) (County) (Stete) Month, Dey, Yeer fectory, street, office bldg., etc.) Hour am While Not While et work et work p.m. 21. I certify that (1) (this hospital) attended the deceased from....... alive on...../.... saw the deceased 22b. DATE 22e. SIGNATUR SIGNED ATTENDING STAFF DIRECTOR PHYS. PHYS. HOSPITAL Path. Page 4 FUNERAL August 228 PHYSICIAN'S 22d. ADDRESS NAME (Type) Dr. Rove Camden Ave., Salisbury, Maryland Earl 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) ÷ 3 August 4,1967 New Cathedral Cemetery 0 Baltimore, Maryland Buria 1967 REGISTRAR'S SIGNATURE 25e. REC'D BY 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) HOLLOWAY & COMPANY, SALISBURY, MARYLAND 15M 7-62 DATE

death certificate be

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND

Mean Harqueres Debr. (Elster) - Francisco. will Christen Ave. - Salisbury, Mary Line

SHAROLET STANKING Detapool afair bon- abreal attended to a top h whose mattaking a norogon inchession faga-actions Caroline tarlus Laye artanoselaster Heart Deserve you Conden Employee. AC mithud , TELLET The state of the s

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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MIED	ICAL EXAMINER 3	CERTIFICATE O			
o. COUNTY WICOMICO	MARYLAND	o. STATE	Where deceosed lived, if instituti b. COUN IWare		fore odmission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give peopest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If ou	tside corporate limits, write RUR	RAL ond give neo	rest town)
SALISBURY"		Dags	sboro	THE PART OF	46-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital,	give street oddress)	d. STREET ADDRESS Rur	9.3		e. IS RESIDENCE ON A FARM?
DOA PENINSULA GENERAL	HOSPITAL	Rul	al		YES NO
B. NAME OF First DECEASED (Type or print) JAMES	Middle LEE WIMBI	ROW Lost	DEATH	h 22-67	loy Year 19
SEX 6. COLOR OR RACE 7. MARRIED WIDOWED WIDOWED	NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH 9-13-16	9. AGE (In years lost year)	Months Doy	
	IND OF BUSINESS OR NDUSTRY	11. BIRTHPLACE (Stote Marylan		12. CITIZEN	
3. FATHER'S NAME Frank Wimbrow		14. MOTHER'S MAIDEN N Anna Ma	e Wimbrow		
20 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	SOCIAL SECURITY NO. 17. I	NFORMANT Katheryn W	imbrow, Dags		el.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), stating the underlying couse last. (c)	oronary occlus	ION		· ·	SWEET AND PEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE COM	IDITION GIVEN IN PART I(0)		9. WAS AUTOPSY PERFORMED? YES NO
PRIMARY Or CONTRIBUTING CAUSE OF DEATH.	ESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in	Port I or Port II of item 1B.)		
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 20d. While of wor	Not While foct	CE OF INJURY (Home, form ory, street, office bldg., etc.)	, 20f. (City or town)	(County)	(Slote)
21. I certify that I took charge af the red death resulted from: Natural cardes [ACTUAL SIGNATURE EXAMMER'S Earl L. Royer, A		ide, Hamicide CHIEF MEDICAL M.D. ASSISTANT MED DEPUTY MEDICAL	Undetermined m EXAMINER ICAL EXAMINER	anner 🗌	nd in my opinio
EXAMMER'S LOS Camden Ave 1409 Camden Ave 1230. BURIAL, CREMATION, REMOVALUSAGEDY 123b. DATE THEREOF 8-25-67	Salisbury, Md 23c. NAME OF CEMETERY OR Carey's Ce	Address (Street	, city, town, or county) 23d. LOCATION (City or To		24, 1967
24 FUNERAL DIRECTOR MA. ()	ADDRESS	I 2So. REC'I	BY REGISTRAR 25b. RE	GISTRAR'S SIGNA	UKK

Millsboro, Del.

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DATISEP

5 may be retained for yaur files.

MEDICAL EXAMINER:

O DEPUTY